REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **Hospital Director,** **Priory Hospital,** **Roehampton,** **Priory Lane,** **London.** **SW15 5JJ** 2. [redacted] **Director of Health and Safety,** **Priory Hospital,** **Roehampton,** **Priory Lane,** **London.** **SW15 5JJ.** 3. **Care Quality Commission,** **Legal Services,** **Citygate,** **Gallowgate,** **Newcastle-upon-Tyne.** **NE1 4PA.** 4. **Director of Mental Health Commissioning,** **NHS England,** **PO Box 16738,** **Redditch,** **B97 9PT.**
1	**CORONER** I am Dr Fiona Wilcox , HM Senior Coroner, for the coroner area of Inner West London
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION** On 30th September 2013 I commenced an investigation into the death of Francesca Whyatt, aged 21 years. The investigation has not yet concluded and the inquest has not yet been heard.
4	**CIRCUMSTANCES OF THE DEATH** Francesca Whyatt had been admitted to the Priory Hospital, Roehampton in March of 2013 under section 3 of the Mental Health Act to its specialist Personality Disorder Unit situated on East Wing Ward, (now named Emerald Ward). This unit is an NHS funded

unit which accepts patients from all over England and Wales, where local treatment has been unsuccessful. Many of the patients resident on the ward are deemed as high risk and all require complex and expert care.

On Wednesday 25th September 2013, Ms Whyatt was found unconscious in a living room on the ward, with a pair of tights tied tightly around her neck as a ligature. Attempts were made to resuscitate her at the scene and she was taken to Kingston Hospital where she was recognised as life extinct at or about 11:50 hours on Saturday 28th September 2013.

Following post mortem examination the interim cause of death has been given as :

1 (a) Irreversible cerebral anoxia
(b) Upper airways obstruction.

The death has been subject to a police led investigation.

Ms Whyatt was recognised as being at high risk of self harm, and made multiple serious attempts to harm herself whilst on the ward prior to the incident which led to and caused her death. There were approximately nine previous incidents of self ligature, including one particular incident on 7th August 2013, which was described by staff as a "near miss", in that she had almost died. This had occurred when she was supposed to have been on 1:1 observations, She had also been able to procure razor blades, swallow one and cut herself badly enough to require skin grafting and even pick up a jigsaw blade which had been dropped in error by a work man on the ward, despite being on close observations, and tried to drown herself in the bath. Many of these incidents, including that of 7th August appear not to have been signed off by senior staff members.

On 28th August 2013, her psychiatrist had written in her notes:
"She remains at high risk of suicide and I have not reduced her observations and will not do so until I am more confident about the risk being reduced. I have reduced them in the past only to find Frankie suffers a serious incident in the ensuing days."

She had expressed to her psychologist on 11th September 2013 that she was waiting to be reduced from 1:1 observations and then would implement a plan to self harm.

Her last risk assessment dated 21/9/2013 concluded "Do not let Frankie into the bathroom without supervision at all times, do not leave her unattended for any reason at any time."

Ms Whyatt had received 6 compulsory sessions of ECT in the immediate time leading up to her death since she had been refusing to eat and drink, and had only just started to eat on 23rd September 2013. On the same day she is recorded as appearing very low in her mood.

At around 15:30 on 23rd September 2013, at the MDT meeting on the ward, her observations were apparently reduced from 1:1 to 15mins observations during the day remaining 1:1 at night. However, this decision was not documented in her records until after the incident that led to and caused her death nor is there any recorded consideration of risk either in the records or as a formal documented risk assessment.

The police have reported that nearly all members of nursing team on the ward at the relevant time were new or had very limited training. The ward was highly dependant on agency staff. Issues have been identified with training and induction. Some staff had not been shown where resuscitation equipment nor ligature cutters were kept on the ward, causing potential delays in their use during Ms Whyatt's resuscitation. There was confusion amongst the staff as to how observations should be carried out and recorded. The ward at the time was not properly secured such that another patient was able to abscond through an inappropriately left open door. There has been some evidence gathered that suggests that many of the new and or agency staff were insufficiently

	experienced to assist the patients with therapeutic interventions. Attending police officers described the ward as chaotic and disorganised. They were already present on the ward having been called initially by other patients, then later by staff, to assist with another patient who was self-harming. In an email of 13th August 2013, the then acting manager of the ward brought the attention of the senior hospital management team, including [redacted] and [redacted] the ward's consultant psychiatrist, her concerns that the ward was unsafe, due the lack of training and expertise of the staff and cited Ms Whyatt's self ligature attempt of 7th August 2013, as an example of this.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) That the ward is simply unsafe for the patients cared for there. (2) That the staff on the ward are insufficiently trained and experienced. (3) That the observation policy is poorly understood and applied. (4) That there is over-reliance on agency staff. (5) The patients are not properly risk assessed. (6) Risk assessments are not properly recorded. (7) Patient records are not kept up to date and important decisions not recorded. (8) The staff have inadequate induction. (9) That there appears to be no named nurse system. (10) That the CQC appear to be unaware of these safety issues despite recent inspection. (11) That the hospital senior management team appears to have failed to act upon legitimate safety concerns raised by the acting ward manager. (12) Lessons have not been learned from previous serious incidents on the ward. (13) Recommendations made following previous serious incidents have not been acted on.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. **It is for each of the individuals or agencies to whom this report is addressed to identify any specific and appropriate action that should be taken on their or their organisation's behalf in relation to the concerns listed above.**

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 29th April 2013. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Family of Ms Whyatt, [redacted] MRH Solicitors (email: NBerry@mrhsolicitors.co.uk) DC Maria Cox (Maria .L.Cox@ met.pnn.police.uk) ; [redacted] Inspectorate of Health and Safety, Rose Court, 2, Southwark Bridge, London. SE1 9HSH. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**3rd March 2013.**  **Dr Fiona Wilcox,** **HM Senior Coroner Inner West London,** **Westminster Coroner's Court,** **SW1P 2ED.** **65, Horseferry Road,** **London.**