Re : CHARLOTTE ANNE AGNEW DECEASED

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** North Essex Partnership University NHS Foundation Trust
1	**CORONER** I am Alison Hewitt, Senior Coroner for the City of 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 and INQUEST** I commenced an investigation into the death of Charlotte Anne Agnew which was concluded at the end of the inquest on 31st January 2017. My conclusion as to the death was : "Suicide. The Deceased's suicide was possibly contributed to by the failure of North Essex Partnership University NHS Foundation Trust to (i) provide any psychiatric treatment and care after 16 February 2016, despite a recognised urgent need for the same, and (ii) put in place any plan for the management of her risk of suicide."
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of Charlotte Agnew's death can be summarised as follows : Charlotte Agnew became psychiatrically unwell in late 2015 and her symptoms worsened over the following weeks. On 9 February 2016 her General Practitioner referred her to the North Essex Partnership University NHS Foundation Trust's psychiatric services on the basis that

	she may be suffering a psychosis. The Trust was also made aware that the Deceased was experiencing suicidal ideation. On 15 February 2016 she was assessed by the Trust's Early Intervention and Assertive Psychosis Team who recognised that she was in need of psychiatric treatment and care but decided that it was not appropriate for her to be managed by the EIAP team. The Deceased was referred on to other psychiatric teams within the Trust but no effective transfer of her care was made and her case was closed. No plan was put in place to manage the Deceased's risk of suicide. On 15 March 2016 the Deceased's General Practitioner made a further referral to the Trust's psychiatric services, seeking an urgent assessment. The Trust's Access and Assessment Team provided an appointment for 20 April 2016. In the days prior to her death on 25 March 2016 the Deceased again expressed suicidal ideation but on the morning of 25 March she did not display to her family signs of being acutely suicidal. In the afternoon the Deceased travelled to London, ingested dangerously high levels of alcohol and medication and, at approximately 4.00pm, jumped in to the path of a London Underground tube train as it entered Chancery Lane station.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken in respect of the matters which have not yet been addressed or sufficiently addressed. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows : It was apparent from the evidence that there were five principal failures by the Trust in relation to the treatment and care provided to the Deceased. These were: (1) The Deceased was first assessed by the Trust's Early Intervention and Assertive Psychosis Team who recognised that she was in need of psychiatric treatment and care by another team but, despite referring her on to other psychiatric teams within the Trust, made no effective transfer of her care before discharging her back to her General Practitioner and closing her case. A significant number of clinical and managerial staff were involved in this process and none of them prevented the Deceased's premature discharge. (2) Prior to the Deceased's discharge no sufficient assessment was made of her risk of suicide. Despite at least two clinical staff being involved, there was insufficient evidence gathering, including from the Deceased's family, and a wholly inadequate assessment was made despite the use of the Trust's electronic assessment tool (which was not properly completed). Further, no plan was put in place to manage the Deceased's

	recognised risk of suicide. (3) Prior to the Deceased's discharge no care plan was put in place and no single person had responsibility for ensuring her care was properly assessed, co-ordinated and delivered prior to discharge. (4) The Deceased was discharged back to the care of her General Practitioner with a recommendation for the prescription of psychiatric medication without her having been seen or assessed by the psychiatrist who made the recommendation and with no means of monitoring its subsequent effectiveness. (5) Despite the matters set out in (1) to (4), the General Practitioner's request, made on 15 March 2016, for an urgent assessment was not granted and the Trust's Access and Assessment Team provided an appointment for a date five weeks later on 20 April 2016. I was told by witnesses from the Trust (and in submissions made on behalf of the Trust) that the Trust had adequate relevant policies and procedures in place at the time and that the failings set out above occurred because all the staff involved failed to follow those policies and procedures. It was said that there has been no subsequent amendment of the policies and procedures but, in summary, that staff have been reminded of them and what ought to happen (by email) and there is now an increased level of monitoring of compliance. Whilst the staff directly involved, who gave oral evidence at the inquest, told me that they now understand that the above failings ought not to have happened and would not occur now, I remain concerned that one or more of the above failings could recur in the future. Although the Trust has taken steps to inform current staff of what went wrong in the Deceased's case, it has not taken steps to ensure that the above failings could not occur again (whether by amendment or clarification of its policies and/or procedures or sufficient training of staff or otherwise). Most particularly, the evidence provided to me did not satisfy me that the Trust's policies and procedures, and the training given upon them, now ensure that every patient who is referred to the Trust will be assessed and treated in a timely manner, even if transfer between teams is necessary. Nor did it satisfy me that every patient's risk of suicide is now properly assessed and managed so as to ensure the risk is minimised. In all the circumstances I consider that there is an ongoing risk that any one or more of the above failings could recur. If that risk is permitted to continue, it could have an adverse impact on the assessment, treatment and care of current and future patients and upon the protection of their lives.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths by addressing the concerns set out above and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 16th June 2017. 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, to the following Interested Persons and to the others listed below who may find it useful or of interest : [redacted] [redacted] HM Senior Coroner for Essex I am also under a duty to send to 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	**20th April 2017 (Re-issued)** **Alison Hewitt**