Regulation 28: Prevention of Future Deaths report

Agnes Stephanie LAMBERT (died 30.06.18)

	THIS REPORT IS BEING SENT TO: **1. Ms Wendy Wallace** **Chief Executive** **Camden & Islington NHS Foundation Trust (C&I)** **4th Floor, East Wing** **St Pancras Hospital** **4 St Pancras Way** **London NW1 0PE**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 3 July 2018, I commenced an investigation into the death Agnes Stephanie LAMBERT. The investigation concluded at the end of the inquest earlier today. I made a determination of suicide at inquest. The medical cause of death was 1a) suspension by ligature.
4	**CIRCUMSTANCES OF THE DEATH** Agnes Lambert was a mental health nurse working at Highgate Mental Health Centre. Following allegations that she had failed to follow a direct instruction not to engage with a patient who was fixated on her, and that she had entered his room at night without telling other members of staff, she was investigated by the trust in the six months preceding her death.

	The investigation had been concluded by the time of Ms Lambert's death and she was just about to return to work, but a day or two before she died she was very upset by a colleague's remark that everyone at Highgate knew of the allegations and believed them.
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 the circumstances, it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. 1. Two weeks before the allegations were made and the investigation began (i.e. two weeks before the occasion of Nurse Lambert entering the patient's room), the patient in question argued with another patient whom he thought was stealing his fiancée. He and Nurse Lambert were not engaged. They were not in a romantic relationship. The more senior member of staff who dealt with the matter, recognised the patient's fixation and thought that Agnes Lambert should move to work on another ward. However, when Nurse Lambert declined because she did not regard the matter as serious, the manager, who had seniority and more experience, did not insist. The service manager who gave evidence in court accepted that the move should have been made regardless of the staff nurse's wishes. If it had been, Nurse Lambert would not have been in a position to enter the patient's room a fortnight later. 2. Following the allegations, it then took the trust four months (rather than the expected four weeks) to interview eight witnesses in order to progress to a disciplinary hearing. This was a distressing time for Ms Lambert and she finally went on sick leave. The service manager who gave evidence in court agreed that this was an unacceptable delay.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 18 February 2019. 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 following. • HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • Care Quality Commission for England • [redacted] Agnes Lambert's parents 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 17.12.18