Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 . **The Chief Executive Officer for the Sussex Partnership NHS Foundation Trust, Ms Sam Allen**

2 **The Chief Executive Officer for the NHS Brighton and Hove Clinical Commissioning Group, Mr Adam Doyle**

1 CORONER

I am Sean Horstead, HM Assistant Coroner for the City of Brighton and Hove.

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

On 29th January 2019 an investigation was commenced into the death of 26 year old Bethany Ella Tenquist. The investigation concluded at the end of a two-week jury inquest, on 22nd November 2019. The conclusion of the inquest was:

Medical cause of death:

ia Hypoxic ischaemic brain injury;
ib Hanging

ii Emotionally unstable personality disorder

The jury provided a *short form conclusion* of 'accident' together with an expanded *narrative conclusion* in which they concluded that the following matters probably contributed to Bethany Tenquist's death:

- The failure of staff to make one or more safe-guarding referrals leading to a lack of safety plans for stock-piling of drugs, access to alcohol and allegations of bullying by another patient;
- In the hours before she used the ligature, Ms Tenquist's exceptionally high level of risk of self-harm or suicide was not appropriately assessed by staff as a consequence of inadequate implementation of the risk assessment procedure and poor communication;
- In the hours preceding her use of the ligature, Ms Tenquist's risk of self-harm or suicide was not appropriately managed with regard to the following:

(i) Complaints raised with staff concerning allegations of bullying;
(ii) Her ability to access alcohol;
(iii) Her night time medications being administered whilst she was intoxicated;

(iv) Inadequate searching to remove all possible ligatures from her room;
(v) Inadequate levels of observations.

- There was an inadequate system in place to ensure, as far as was reasonably practicable, that alcohol was not available to patients on Caburn Ward, specifically:

(i) Lack of induction/training for staff in the search policy;
(ii) Inconsistent implementation of the search policy;
(iii) Failure to follow up on intelligence from carers and patients;
(iv) Lack of tailored planning for high risk patients.

- There was an inadequate system in place to ensure that Ms Tenquist's room was appropriately searched and items with which she may self-harm, including obvious potential ligatures, were removed, specifically:

(i) Lack of induction/training of staff in room search policy;
(ii) Inconsistent implementation of the room search policy including the searching of patients;
(iii) Lack of record keeping with regards to room searches including on the handover sheet;
(iv) No clear leadership and accountability with regard to room searches.

- The search of Ms Tenquist's room by members of staff prior to her use of the ligature was inadequate in that it failed to identify the ligature which she then used.

- The nature and extent of staff deployment on the evening of the 29th December 2018 was inadequate with regard to experience and mix of staff on duty led to the following failures:

(i) Ms Tenquist being given her night time medication while suspected of alcohol intake without her being breathalysed by a qualified, registered Mental Health Nurse;
(ii) The inadequate room search, identification and removal of ligatures by Health Care Assistants who were unfamiliar with search policies;
(iii) The lack of a Ward Manager and a Ward Matron led to the inadequate staff deployment on 29th December 2018;
(iv) Inexperience and lack of knowledge of Ms Tenquist's extremely high risk especially while intoxicated led to an inadequate level of observations being agreed.

- The lack of an over-arching, dynamic and patient centred Care Plan led to failures to assess, treat and safe-guard Ms Tenquist appropriately; this included a lack of leadership and clarity of roles and responsibilities.

4 CIRCUMSTANCES OF THE DEATH

Bethany Tenquist, known as Beth, was 26 years old and lived at the family home in Brighton with her mother and siblings. She was the second eldest of six children. Her father did not live in the family home but lived locally. She went to the local secondary school where she reportedly experienced severe bullying but went on to achieve success in her exams. On leaving school, she has worked as a barmaid, and in a Next clothing store, and commenced her nurse training but was unable to complete the course due to her poor mental health, stopping in year 2.

Beth's first referral to mental health services was in March 2012, when her GP referred her to the Brighton Urgent Response Service (BURS) as she was experiencing suicidal thoughts in the context of bulimia. She was assessed by the Brighton and Hove Eating Disorder (BHEDS) Service in April 2012 and received input, accessing the group therapy programme. It was also recommended that mental health input be provided by the Access Team concurrently and a referral to that service was made. The services have since

undergone a re-structure and this team no longer exists having being replaced by Assessment and Treatment Service (ATS). At the time, her mother felt that Beth was extremely unwell and required hospital admission for her bulimia; she reported that Beth did not wish to attend groups and that one to one support would be more beneficial. Due to non-engagement with the service, Beth was discharged from BHEDS in May 2012. Following an assessment from the Access Team, Beth was subsequently discharged from mental health services in July 2012. Beth had no further contact with mental health services until February 2017, when she re-engaged with the BHEDS group programme. In June 2017, BHEDS requested a rapid assessment from the ATS due to Beth having experienced an increase in suicidal thoughts, self-harm and alcohol use.

Self-harm was occurring on a regular basis and appeared to have taken over from her bulimia as a means of coping with feelings of panic and anxiety. She reported drinking large amounts of alcohol to help manage anxiety and was advised to contact specialist alcohol services for support. Beth was feeling suicidal most of the time but did not identify any active plans though felt that she may act impulsively. She had been on the ledge of her partner's second floor window on at least four occasions when she had been drinking. From July 2017, there was a rapid deterioration in Beth's mental state in terms of crisis, self-harming behaviours, intoxication, attendance at A&E and detentions and assessments under Section 136 Mental Health Act (MHA) 1983. Her first admission to an acute inpatient ward was for two weeks in September 2017 after she had been found by the police at Beachy Head having had alcohol and being very close to the edge. She was detained to Caburn Ward of Mill View Hospital, Neville Road, Hove under Section 2 of the MHA.

Between January 2018 and what was to be her final admission to Caburn Ward on 27th September 2018 when Beth was detained under section 3 of the MHA, she had no fewer than 30 admissions to A&E with 3 requiring police and/or security interventions and 4 resulting in hospital admission for treatment. In addition, Beth had 7 in-patient admissions to Mill View Hospital over the course of 2018 either as informal admissions or under section 2 of the MHA. The times between her admissions, whilst short, were interspersed with self-harming behaviours involving both alcohol and overdosing on medication. Beth's last admission to Caburn Ward was precipitated by an overdose in the context of alcohol use. This behaviour had not modified despite input from the community mental health teams.

In August 2018, the possibility of looking at a placement to help with the Emotionally Unstable Personality Disorder (EUPD) and bulimia was discussed with Beth and her mother and this was taken forward during her final admission and a referral was made for a specialist Tier 4 Placement.

Whilst on the Caburn Ward from September 2018, Beth's presentation remained similar to that in the community. She was able to access alcohol at times: she would frequently self-harm whilst intoxicated. She had some difficult relationships with other patients including evidence that Beth was subjected to bullying by one and was involved, against her will, in an inappropriate and potentially exploitative sexual relationship with another. It was accepted by the Sussex Partnership NHS Foundation Trust (the Trust) that both of these interactions with other patients should have led to Safe-Guarding Referrals being raised: they were not. It was alleged that Beth had been supplied with alcohol by the patient with whom she was involved in the exploitative sexual relationship, although on other occasions Beth was able to obtain alcohol herself. The jury heard evidence regarding the stock-piling of medication by patients and the swapping of those medications. Beth also reported that she had started to feel hopeless about the future and the process of admission to the specialist unit had been protracted and it was not known when the placement would be available.

On the late afternoon and early evening 29.12.18, Beth and her mother had spoken with staff regarding an alleged assaulted by another patient which Beth told staff she wished to report to the police. Staff noted that Beth appeared to be intoxicated with alcohol. Beth was upset at this suggestion and it was her and her mother's view that the interaction and relationships with the other patients had mirrored Beth's experiences of being bullied at school and that the focus by staff on the alcohol issue meant that this concern was, effectively, being ignored.

Later in the evening Beth was again noted to be intoxicated when was reviewed by the duty doctor after a report from another patient, relayed by a fellow patient to a Health Care Assistant, that Beth had

swallowed glass and a number of tablets. In her evidence, the HCA acknowledged that she had received this information from patients and maintained that she had passed the information onto other medical staff, including the duty doctor. All other staff that night claimed not to have known about the alleged overdose. The duty doctor gave evidence that the HCA had informed her of the suggestion that Beth had swallowed glass but *did not* inform her of the suggestion that Beth had swallowed a significant number of tablets. When challenged, Beth denied swallowing glass. Beth's room was searched and some glass bottles and phone charger cables were removed. However, the nursing staff failed to remove the belt from the dressing gown Beth was wearing at the time.

Although the nurse in charge claimed that she had directed during her hand-over from the late to the night shift that Beth was not to receive her evening medication until she had been breathalysed (which Beth had refused) an RMN member of Agency staff (who was working his first shift on Caburn) nonetheless provided Beth with her medication.

Following her assessment, the duty doctor placed Beth on *'enhanced intermittent observations'* to be carried out not more than 15 minutes apart due to her intoxicated state and to further monitor the claim that she had swallowed glass. The evidence of the duty doctor was that, had she been made aware of the suggestion that Beth had taken a quantity of unidentified tablets, then she would not have left Beth alone, she would have instigated constant observations and treated the situation as a medical emergency. The evidence of the former patient who raised the alarm having, she said, seen Beth swallowing the shards of glass and "a mound" of tablets was read to the jury: she was, she said, very upset with staff that her serious concerns about Beth were not being taken sufficiently seriously.

There was unanimity amongst the medical staff who gave evidence (save the RMN who actually administered the medication) that, in circumstances where a patient was suspected of having consumed alcohol, her night time medication must be withheld until a breathalyser had been deployed. In addition, it was accepted that in circumstances where an unknown quantity of unknown tablets had been allegedly consumed in the context of suspected alcohol consumption, then this should be treated as a medical emergency and an ambulance should have been called. The obvious risk was that the regular medication and/or the unknown tablets when combined with alcohol may lead to a depression of respiratory function and/or have a further and exaggerated disinhibiting effect, which was of particular significance in the context of Beth's well-established impulsivity, itself consequent upon her EUPD.

It was during the first intermittent check that Beth was found behind her door; she had used her dressing gown cord as a ligature. She was discovered by a HCA who admitted in evidence that she was not confident in first aid procedures. The observations log suggested that Beth was seen by staff at 23:02, and the evidence from some staff was that she was discovered some 15 minutes later during the first intermittent observation. The timeline was not accepted by all staff. CPR was commenced by staff until the paramedics arrived and took over. CPR was administered upon discovery of Beth but the ambulance was not called until 23:31. Ambulance staff were told by an unnamed member of staff from Caburn Ward that Beth had been seen earlier that night "staggering" along the ward back to her room and had been left alone for 10 minutes. So concerned were the paramedics by this information that they raised their own Vulnerable Persons Referral.

Beth was taken to the Brighton and Sussex County Hospital (RSCH) where she was cared for on the Intensive Care Unit. She sadly died, without regaining consciousness, on 16th January 2019 from an ischaemic hypoxic brain injury.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

1. The search policy and Beth's access to alcohol on a frequent basis

   Given Beth's extremely high risk of self-harm or suicide (described by the her Responsible Clinician, a highly experienced psychologist, as one of the very highest risk patients she had encountered in her lengthy career) and characterised by high levels of impulsivity, I have grave concerns that Beth had frequent access to alcohol whilst detained under section 3 of the MHA on an acute ward. It was, or should have been, widely recognised by all staff that an *even greater* elevation of the already exceptionally high risk of self-harm or suicide would be occasioned by Beth's access to alcohol; the jury have confirmed that, notwithstanding this clear danger to her safety, there was a persistent and on-going failure to ensure all reasonable steps were taken to ensure that alcohol was not available on the ward. It has been conceded by the Trust that searching policy was inconsistent and ineffective. Whilst I have received evidence with respect to a more robust approach to daily environmental checks having now been introduced, I remain concerned that there is an insufficiently robust and effective system in place for the effective searching of voluntary patients, those detained patients returning from section 17 leave and all visitors to Caburn Ward. The continued absence of dedicated security staff at the entrance to Caburn Ward, during the hours that patients and visitors may arrive, gives rise to a risk of future deaths should alcohol continue to find a route onto the ward.

2. Staff training and auditing.

   The evidence regarding the wholly inadequate completion of the handover and the accompanying documents in this case is of serious concern, again as reflected by the jury's conclusion. The handover from late to night shift was chaotic and confused at best. The paperwork was in large parts either wholly inadequately completed or simply not completed at all. All of the agency and bank staff were either new, or at best, had only had worked a few shifts on Caburn. This clearly elevates the critical importance of a detailed, thorough and professional handover together with full and far more professional completion of the accompanying documentation. I specifically require identification of the steps proposed to dramatically improve these matters.

3. First aid training.

   I am gravely concerned by the evidence that not all health care staff working on Caburn Ward were adequately trained in emergency life support or first aid. It is axiomatic that *all* members of health care staff must be competent and able to deal with circumstances were first aid skills may need to be deployed. At least one member of staff admitted that she did not have these skills even when she gave evidence to the jury, notwithstanding that she had been appointed as a substantive member of staff some seven months following the death, and three months before she gave evidence.

4. Care Plan not Up-dated.

   It was accepted by the Trust that Beth's Care Plan had not, contrary to requirements of the Care Programme Arrangement, been updated in any meaningful way throughout Beth's three month section 3 detention prior to her death. As the Clinical Lead Nurse Manager conceded, in the absence of patient centred involvement in the up-dating of the Care Plan, it risks becoming *"meaningless"* to the patient. In circumstances where a co-authored and co-produced document that actively involves and engages the patient is simply not up-dated meaningfully at all, then the aims and purposes of the CPA risk being undermined. In the context of a patient with Beth's co-morbidities, the impact may be very serious indeed. The jury's conclusions in this respect are informative and clear.

5. Staffing levels.

It was accepted by the Unit Co-ordinator, the Clinical Lead Nurse Manager and on behalf of the Trust, that on 29th December 2018 staffing levels on Caburn Ward had reached crisis point: there had been no Ward Manager and no Matron in post and available for a significant period of time, in conjunction with a 50% reduction of substantive staff. There was a reliance on bank and agency staff, and - unsurprisingly in my view - low staff morale. A number of members of staff in evidence emphasised that they had raised the issue of staffing and their concerns with managers and senior managers, to no avail. The obvious concern is that in the context of an acute female ward, such as Caburn, but equally applicable to the male acute ward, where the cohort pf patients have such complex and challenging mental health issues, it is critically important that there is a consistency of staffing, management and leadership. The conclusion of the jury reflects and reinforces my concern that the extensive reliance on bank and agency staff undermines the safe operation of the acute wards at Mill View Hospital and, should the position persist, gives rise to the risk of future deaths.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisations) 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, 10th December 2019, namely by 4th February 2020. 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:

[redacted] (mother of the Deceased)
[redacted] (father of the deceased)

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

Signed: **Sean Horstead, HM Assistant Coroner for the City of Brighton and Hove**

Dated: 10.12.2019