Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive** **Norfolk and Suffolk NHs Foundation Trust** **Trust Management** **Hellesdon Hospital** **Drayton High Road** **Norwich** **NR6 5BE**
1	**CORONER** I am JACQUELINE LAKEJacqueline LAKE, HM SENIOR CORONER for the area of Norfolk
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 23 April 2020 I commenced an investigation into the death of Eliot HARRIS aged 48. The investigation concluded at the end of the inquest on 08 August 2022. The conclusion of the inquest was Medical Cause of Death: 1a) Unascertained Conclusion: Open – the evidence does not reveal the means by which Eliot Harris came by his death
4	**CIRCUMSTANCES OF THE DEATH** Eliot Harris had schizophrenia and diabetes. Eliot had not been taking medication for several days and his condition deteriorated. He was admitted to Northgate under the Mental Health Act after assessment on 5 April. He was initially in seclusion then on the ward from 6 April, he spent a lot of time in his room and only ate cheese sandwiches. He only accepted medication in intramuscular form and on 9 April by depot injection. His physical observations were recorded as being normal, and a blood test on 7 April showed he did not have diabetes. His intake of food and fluid remained minimal but he was not put on a chart to monitor this. Staff last entered his room at 17:46 on 9 April. He was last seen conscious at 18:10 on 9 April. He was found unresponsive at 01:33 and declared dead at 02:00. An ECG was recommended and requested to be carried out but had not been carried out by the time of Eliot's death. It cannot be concluded, based on the evidence, that the matter of an ECG not being obtained caused or more than minimally, negligibly or trivially contributed to Eliot's death. As at April 2020 there was a culture within Northgate Hospital of retrospective recording of: - observations done but not contemporaneously recorded and with insufficient detail - some observations were falsified, either by completing records for observations that were not done or by completing records and signing on another's behalf - observations were completed by staff who had inadequate training

	In respect of the retroactive recording, it is further acknowledged that the aforesaid was encouraged and expected by the ward managers and at times the recordings would be done days later. The matter of observations, based on the evidence, did not cause or more than minimally negligibly or trivially contribute to Eliot's death. On the night of the 9 and 10 April 2020, observations were found lacking. These include: - failure to complete observations - observations done but contemporaneously recorded and with insufficient detail - some observations were falsified, either by completing records for observations that were not done or by completing records and signing on another's behalf - observations were completed by staff who had inadequate training - observations were carried out but were insufficient to properly inform the observer whether Eliot was alert and breathing, or whether he was well. The matter of observations, based on the evidence, did not cause or more than minimally negligibly or trivially contribute to Eliot's death.
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 could 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) Substantial evidence was heard at the inquest with regard to observations which were not carried out in respect of Eliot Harris in accordance with NSFT's Policy and with regard to staff not undergoing training and assessment of their competency to carry out observations correctly. Quality audits undertaken following Eliot Harris's death, show that observations are still not being carried out and recorded in accordance with NSFT's most recent policy – more than two years following Eliot's death. Not all staff have completed training with regard to carrying out of observations or have undergone and assessment of their competency to carry out observations 2) On the night of Eliot's death, a Nurse in Charge had not been allocated and members of staff were not allocated specific tasks – they were told to "muck in", as a result there was some confusion as to who was responsible for specific jobs. The evidence at the inquest was not clear as to whether specific tasks are allocated to specific members of staff on Night Duty and whether and how a Nurse in Charge is appointed for each night's rota 3) Multi Team Meetings were not fully and properly recorded in the clinical records. At the inquest, evidence was heard there "is still some way to go" with regard to improving record keeping and for ensuring important matters such as rationale for decisions is fully recorded 4) Eliot's Care Plan was not up to date at the time of his death. At the inquest evidence was heard that although audits show there has been an improvement in completion of Care Plans, there "is still some way to go" and staff still need to be prompted to complete these 5) Staff were reluctant to enter Eliot's room following concern for his wellbeing. The evidence did not reveal what is now in place to ensure staff enter a patient's room immediately if there are concerns for a patient's welfare (having considered their (staff's) own safety) 6) It is not clear from the evidence what is now in place to ensure that relevant and requested physical health checks are carried out. The process of ensuring health checks are carried out has not changed since Eliot's death and remains a retrospective process

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 October 05, 2022. 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], Solicitor representing [redacted] (Mother) [redacted] I have also sent it to Care Quality Commission Department of Health Healthwatch Norfolk NHS England and NHS Improvement who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 22/08/2022** J Lake **Jacqueline LAKE** **Senior Coroner for** **Norfolk**