REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** Inmind Healthcare Group
1	**CORONER** I am Miss Fiona Butler, His Majesty's Assistant Coroner for the coroner area of Leicester City and South Leicestershire
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 29 October 2021, I commenced an investigation into the death of Samantha Jane BOAZMAN aged 54. The investigation concluded at the end of a 10 day inquest on 27 January 2023. The conclusion of the jury was: '*Death by misadventure. We find that there was gross neglect due to a continuous sequence of shortcomings, including a lack of adequate training on the risks and triggers of patients. Failure to remove ligature risks from bedrooms. Inadequate induction and training of temporary staff*'.
4	**CIRCUMSTANCES OF THE DEATH** Samantha Boazman had a diagnosis of Emotionally Unstable Personality Disorder and Dissocial Personality Disorder. She had had a 35 year history with mental health services. Samantha arrived at Sturdee Community Hospital (a locked female rehabilitation ward) in June of 2020, when her community placement had broken down and she could no longer be safely managed within the community. At the time of her death, Samantha was detained under s.3 of the Mental Health Act. On 17th September 2021 whilst on s.17 leave Samantha walked in front of a slow-moving vehicle, she was admitted to A&E with a minor injury to her knee and head injury where she had fallen backwards. She was discharged the same day. On return to Sturdee Community Hospital Samantha was placed on 15 minute observations but was found in her bathroom [redacted] Samantha was moved to a safety room.

On 14th October 2021 Samantha returned to her normal bedroom, room 5.

Observation levels were reduced from 15 minutes to 30 minutes on 21st and 22nd September, and then reduced to hourly observations on 23rd September 2021. The RAG rating records Samantha as being on hourly observations from 23rd September to the date of her death.

On 20th September 2021, Samantha was denied access to 'cables/chargers'. The Jury heard evidence that something coloured red on the RAG rating was a 'high risk'. Cables/chargers were highlighted red and remained contraband items from 20th September to the point of Samantha's death.

Samantha found transitions difficult to go somewhere she didn't know. On 21st October 2021 Samantha was informed that she would be moving to Aylestone Flats within the ground of Sturdee Community Hospital in preparation for moving to the community in the future. A Senior Registered MHN told the Jury that the thought of moving destabilised Samantha.

Samantha had heightened sensitivity as part of her Emotionally Unstable Personality Disorder, so a small thing (not receiving a text message) would be felt more strongly. Her Psychologist saw Samantha on the 21st October and described Samantha as anxious and the reasons for this were not receiving responses to her text messages and also leaving the hospital for a future placement (yet to be identified).

Samantha had been more agitated than usual over the course of the previous week and seeking staff support quite a lot.

No one could recall a discussion about Samantha's risk at the risk management meeting of 22nd October 2021 and if there was a discussion about Samantha's risk, her risk rating wasn't changed on the RAG document.

Various staff gave evidence as to Samantha's presentation on the 22nd October 2021, for example: Samantha was at around 3pm almost irritable; very unsettled and had been more agitated in the days prior to her death and seeking more 1-1 interactions. Samantha was described as unsettled, kept pacing and crying, this was different to what Samantha was like before. Samantha was said to be 'very very' anxious walking up and down asking for the doctor or the nurse in charge.

The CCTV evidence of Samantha on 22 October 2021 between 15.57 hours and 17.33 hours (when Samantha was last seen) showed that between 15.57 and 16.29 hours Samantha can be seen pacing the corridor 27 times within the 32 minute period, and between 16.29 and 17.33, a 64 minutes period, she can be seen pacing the corridor 70 times – more than 1 x per minute.

Health care assistants who were allocated general observations would be allocated these within a 1-hour period, for example 4pm to 5pm. The Jury heard how healthcare assistants had to observe and record the hourly observation for a patient on the hour every hour, none were told to record the actual time they observed the patient, nor was that the Inmind Healthcare Group Policy for Sturdee Community Hospital in place at the time. Healthcare assistants would locate the patient 5 minutes before the hour period was up and then record their observation on the hour and then move to their next patient.

	As far as the purpose of conducting observations, the evidence of the healthcare assistants was that they needed to observe that the patient was safe and if the patient was sleeping, to check if the patient was breathing. Health care assistants were to record the location and what the patient was doing and also to record if the healthcare assistant interacted with the patient and anything else meaningful. If a patient was engaged with something (eg: watching tv) there wasn't an expectation to disturb the patient to interact with them. There was a period of 1 hour and 12 minutes between Samantha closing her bedroom door and it being opened by a healthcare assistant and no was seen entering Samantha's room during that time. No one observed her. Samantha was found at 18.45 hours in her bathroom on 22nd of October 2021 [redacted] A nurse and healthcare assistant answered the alarm at 18.47, just under 2 minutes. There were difficulties in entering Samantha's bathroom because she was behind the door. The 999 call to East Midlands Ambulance Service was received at 18.53 hrs, 8 minutes after the alarm was raised. A trained paramedic co-incidentally arrived at the hospital to work in a different capacity and went to assist, arriving at Samantha's bedroom at 18.53 hours, the same time as the 999 call was being made. The Jury hard in evidence that there was no CPR in progress when she arrived. The paramedic said that ILS training was that you should commence early CPR. The emergency response bag was delayed in being brought to the scene due to being situated on a different ward which required access to another building through locked doors. The defibrillator was being attached during the 999 call and at the point the trained paramedic arrived at the scene. CPR was commenced at a time at least 8 minutes after the alarm was raised, and at a time at least 6 minutes after the alarm was answered. The defibrillator advised no shock indicating that there was no electrical activity within Samantha's heart (asystole). A second round of CPR as advised by the defibrillator, was commenced, but Samantha's pupils were fixed and dilated, she had mottled skin, which she described was a bruising effect when the body has been lying for some time and as advised by the Resuscitation Council UK, CPR was ceased to preserve Samantha's dignity. Paramedics attended and Samantha was pronounced dead at 19:15 hours.
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: (brief summary of matters of concern)

1. Emergency Response

I heard during the course of the inquest that when an alarm sounded staff would attend the location of the alarm, assess the situation and then go and collect what equipment may be necessary to deal with the emergency.

At the time of Samantha's death there was only 1 emergency bag for the entire hospital (which had 2 wards and separate self-contained flats on the site). This has now been rectified and there is an emergency bag for every ward.

Staff partake in a drill and evidence provided to me for the purposes of Regulation 28 showed that response times of staff remain at 2 minutes to a patient's side.

However, I was told that the emergency response still has staff attend a patient, assess and then go and collect the emergency bag, rather than taking it immediately to the patient's side.

I was provided with evidence for the purposes of Regulation 28 by Inmind Healthcare Group which showed, for example, that in December of 2022 there were 64 incidents, 45 of which were self-harm, 2 of which were clinical incidents. 16 resulted in actual harm and a large number of those incidents concerned patients ligating.

To continue with an emergency response which delays the provision of life saving equipment to the patients' side is unsafe and in my opinion could lead to future deaths.

The delay in providing CPR to Samantha on balance had no causative effect on her death, but it could for another patient.

2. Observation Policy

At the time of Samantha's death observations were conducted and recorded in a predictable and prescriptive way by healthcare staff. The quality of observations recorded at the time of Samantha's death were such that they did not accord with the expectation of the policy and merely recorded where the patient was and what they were doing.

Effective observations were acknowledged as being a vital tool to assess and manage the risk of a patient.

Inmind Healthcare Group's new observation Policy states:

'Observations are a therapeutic intervention aimed at reducing factors which contribute to increased risk and promoting recovery. The use of enhanced observation levels should never be regarded as routine practice…….
Observation practice must focus on engaging the person therapeutically and enabling them to address their difficulties constructively. Our interactions must seek to create rapport which allows those in our care to feel valued and safe to share their experiences with us'.

Since Samantha's death changes have been made by Inmind Healthcare Group to their policy

	and practice, in that observations are now recorded at the precise time they are conducted and are infrequent in their predictability (eg: hourly observation should be conducted once hourly rather than on the hour every hour). Evidence of recent observation records demonstrated that this was now practice. However, there was a disconnect between the new policy and the pre-printed forms being used to record observations; what staff were being instructed to do and what they were recording. This was confusing and the evidence produced did not support the expectations of the new policy or demonstrate it had become embedded practice. The evidence produced did not support a change in staff recording quality observations, so that whilst precise and intermittent timings were evidenced, beyond the location of the patient or what they were doing, the actual presentation of the patient was not being recorded.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 **March 27, 2023**. 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 i. The family of Samantha Boazman [redacted] iv. Care Quality Commission I have also sent it to East Midlands Ambulance Service 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: 31/01/2023**  **Miss F BUTLER** **His Majesty's Assistant Coroner for Leicester City and South Leicestershire**