REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] CEO, Essex Partnership NHS Foundation Trust**
1	**CORONER** I am Sonia Hayes, Area Coroner, for the coroner area of Essex
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 2 September 2019 an investigation was commenced into the death of Sharon Elizabeth LANGLEY, aged 62 years. Sharon Elizabeth Langley died on the 10 August 2019. The investigation concluded at the end of the 10-day inquest on 21 February 2023. The conclusion of the inquest was Suicide with narrative with a medical cause of death of '1a Immersion in Water (Drowning) 1b Severe Depressive Disorder with Psychosis.
4	**CIRCUMSTANCES OF THE DEATH** On 10 August 2019 at the Princess Alexandra Hospital, Hamstel Road, Essex, Sharon Elizabeth Langley an inpatient with Severe Depressive Disorder and Psychosis died by Immersion in Water unsupervised in an assisted bathroom on Chelmer Ward. Following several documented suicide attempts the latest on 7 July 2019 Sharon Elizabeth Langley took the actions to immerse herself in the water in the bath and did so with the intention to end her life. Therefore, we return a conclusion of Suicide with the following additional narrative. Sharon was taken for a supervised bath and access was granted by staff to the bathroom at 09:33:57. The evidence shows staff who should have been assisting Sharon were in other places on the ward at the time of her bath, suggesting she was left alone and unsupervised. Although not formally documented evidence was heard Sharon should be assisted whilst having a bath. Sharon was found face down and unclothes in a bath with water at around 10am

	by the healthcare assistants who pulled her out of the bath and laid her on the floor next to the bath. Initial staff response was inadequate and insufficient causing a delay in triggering the pinpoint alarm and ambulance being called. However, when nurses arrived emergency treatment was adequate with evidence showing the AED was used correctly. Paramedics arrived on the scene within 3 minutes to take over emergency aid. The paramedics lacked information about the incident from staff and Sharon was taken to the Accident and Emergency department at 10:39 where she was declared dead.
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) Essex Partnership NHS Foundation Trust staff immediate emergency response was not followed: a. pinpoint alarms were not activated immediately on finding Sharon Langley unresponsive b. there was a delay calling the ambulance and basic key information about the type of the emergency was not relayed: i. by qualified nurses who made the 999 calls, or ii. to paramedics on attendance c. there was a delay informing the site co-ordinator of the emergency even though she was based on the ward and there was a lack of co-ordination of the emergency resulting in the ambulance being called a second time by the site co-ordinator d. staff trained in basic life support did not assist the two nurses who were attempting to resuscitate Sharon Langley (2) There was a difference in the safety measures fitted to the bathroom door on the adjoining Stort Ward that had a self-closure mechanism at the time of Sharon's death. This mechanism has now been fitted to Chelmer Ward. There is a concern that safety information is not shared

across the Trust and known risks are not mitigated appropriately.

(3) The Trust was on notice of issues on Chelmer ward with doors to high-risk areas not closing that included the Staff Room and Patient Storeroom.

a. At the time of Sharon's death, the mitigation on the ward was for staff to push doors to see if they were locked, this was action even though evidence was heard that these doors had keylocks and staff had keys that could have been used.
b. The Patient Storeroom contains items removed from patients as they pose a significant self-harm risk and/or suicide.
c. Staff Room that contains items that pose a risk to patients

Self-closure mechanisms have not been fitted to these doors in a high-risk environment of a secure psychiatric ward even though the risk is known. Evidence was heard from patient safety that it is sufficient to have maintenance manually adjust doors if there are closure issues.

(4) Chelmer Ward staff did not always report door closure issues either on the ward to the Nurse in Charge or to maintenance. Following the death of Sharon Langley there has been no training on how to report door closure issues reported.

(5) Evidence was heard that the bath plug was required to be kept in the ward office when not in use as the bathroom was a high-risk area. There was no evidence that staff had to obtain this from the office on the day Sharon Langley died. There still appears to be confusion around the requirement.

(6) There is concern about the reliability of the Trust investigation and how the Trust learns lessons. The investigation report did not:

a. scrutinise the movements of staff even though the door logs were available or raise any issues for further investigation
b. raise any issues around the bath plug or where it should be kept
c. investigate concerns raised around the Trust staff emergency response or failure to provide basic information on the incident to paramedics

(7) The Trust investigation author changed the conclusion of his report during the inquest when he received statements provided by staff that were not requested and contained timing information that in evidence

	staff stated they did not know. (8) Quality of record keeping was not deemed to be appropriate by senior staff during evidence: a. Significant examples of cut and paste including out-of-date risk information at all grades of ward staff, and b. omissions in multi-disciplinary decision-making and risk of self-harm with no rationale for the level of observations set for the patient and a plan for how risks should be managed
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 Monday 24 April 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: • [redacted] (Mother) • Care Quality Commission 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	 **27.02.2023** **HM Area Coroner for Essex Sonia Hayes**