Best care by the best people

NELFT NHS
NHS Foundation Trust

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Mr Graeme Irvine
HM Senior Coroner
East London Coroners Court
124 Queens Road
Walthamstow, London
E17 8QP

[redacted]
Acting Chief Executive
Trust Head Office
West Wing
CEME Centre
Rainham
Essex
RM13 8GQ
[redacted]

[redacted]

22 June 2023

[redacted]

Dear Sir

Re: Inquest touching upon the death of Winbourne CHARLES

I refer to your Regulation 28 report dated 28 April 2023, issued in respect of your concerns regarding the risk of future deaths.

Concerns

At the conclusion of the hearing into the death of Winbourne Charles, you expressed concern regarding the following matters:

1. A failure to adequately asses risk of harm - Poor record keeping and a failure to read electronic records meant that important information was not considered at a Multi-Disciplinary Team (MDT) ward round on 06 April 2021. The MDT arrived at a conclusion that Mr Charles' risk of self-harm was "no risk". A psychologist's assessment on the clinical record that assessed Mr Charles' risk of the self-hard as high on 31 March 2021 was neither read nor incorporated into the MDT discussion

2. A decision to reduce observation frequency made by the MDT on 6 April 2021 was not supported by the Trust Policy guidance which indicated that enhanced observations were appropriate.

3. A failure to ensure that a treatment plan was followed - observations between 16.00 and 17.00 on the day of Mr Charles' death were suspended by the ward shift co-ordinator. The decision meant all patients subject to general observation on the ward were ignored.

4. Failure to respond to an emergency adequately - The Trust described the emergency response as chaotic, that Trust staff agreed that they "panicked" and did not follow policy, specific issues include;

    a. A ward emergency bell was not sounded.
    b. An anti-barricade key was not used to open Mr Charles' door, instead the door was forced open causing risk of harm to Mr Charles.
    c. A ligature cutter could not be used promptly as it was secured in a box with a combination lock – staff did not know the combination.

d. Duty doctors were not called promptly.
e. Oxygen administration was delayed.
f. An on-site defibrillator was not used by staff.
g. Staff could or would not provide a clear and relevant history to paramedics.

5. The credibility of evidence provided by Trust staff.

    a. Two Trust witnesses declined to answer questions put to them regarding whether their observation records were truthful.
    b. Observation records appeared to have been created utilising a "cut and paste" function.
    c. Records often inaccurately recorded the prescribed frequency of observation.
    d. Factually inaccurate entries were made in the record following Mr Charles' death. On 11 April 2021 an entry stated that Mr Charles was "Awake in his bedroom sitting on his bede (sic)" at 07.21. On 12 April 2021 two entries made at 09.48 and 11.40 recorded that Mr Charles was alive and well. Senior Trust witnesses characterised these entries as dishonest.

6. Governance process failings.

    a. A Datix incident report created on the evening of 10 April 2021 by a senior nurse and Modern Matron contained misleading information that suggested that emergency response policies were followed when in fact they were not.
    b. The Datix failed to mention that observations had been suspended by the shift coordinator, a fact that was understood at that time. This obvious and significant piece of information that should have been escalated through the Trust governance team for action.
    c. The Trust 72-hour report was written by the Modern Matron and was signed-off by an integrated care director on 15 April 2021. This document also failed to identify or escalate the significant issue of suspension of observation at 16.00 on 10 April 2021.
    d. The Trust SI report presented to the inquest failed to address the poor risk assessment or inadequate Datix & 72-hour reports.

We have carefully considered your Regulation 28 report and by way of response, we attach a detailed action plan addressing the concerns raised by you.

I would like to take this opportunity to thank you for raising your concerns as part of this inquest. We find learning from inquests extremely valuable and are very grateful for your comprehensive investigation, which benefits not only the families of the deceased, but also the Trust and its service users.

I trust that the attached action plan reassures you that the Trust has taken this tragic death very seriously indeed, and that it reflects our commitment to improve care quality and patient safety.

If I can further assist, please do contact my office on [redacted]

Yours sincerely

[redacted]

[redacted]
Acting Chief Executive

Enc: Regulation 28 action plan