MR G IRVINE
SENIOR CORONER
EAST LONDON

[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted] Acting Chief Executive Officer, North East London Foundation Trust [redacted] • Rt Hon Steve Barclay MP, Secretary of State for Health & Social Care [redacted]
1	**CORONER** I am Graeme Irvine, senior coroner, for the coroner area of East London
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 11th April 2021 this Court commenced an investigation into the death of Winbourne Gregory Charles, aged 58. The investigation concluded at the end of the inquest held before a jury between the 17th and 21st April 2023. The Court returned a conclusion of: "Suicide, contributed to by neglect, to which failures in medical intervention contributed and to which failures to respond to an obvious risk of self-harm contributed." Mr Charles' medical cause of death was determined as;

	1a Suspension
4	**CIRCUMSTANCES OF THE DEATH** Winbourne Gregory Charles was a admitted into hospital under section 2 of the Mental Health Act 1983 in November 2020 following an attempt to take his own life. In December 2020 on a diagnosis of depressive illness incorporating psychotic symptoms, Mr Charles was made subject to an order under section 3 of the Mental Health Act 1983. On 10th April 2021 Mr Charles was found unresponsive, suspended [redacted] on the mental health ward.
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 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. A failure to adequately assess 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 6th 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 self-harm as high on 31/3/21 was neither read nor incorporated into the MDT discussion. 2. A decision to reduce observation frequency made by the MDT on 6/4/21 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. Failures to respond to an emergency adequately – The Trust described the emergency response as chaotic . 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 a 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 11th April 2021 an entry stated that Mr Charles was, "Awake in his bedroom sitting on his bede (sic)" at 07.21. On 12th April two entries made at 9.48 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 10th 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 15th April 2021. This document also failed to identify or escalate the significant issue of the suspension of observation at 16.00 on 10th April 2021. d. The Trust SI report presented to the inquest failed to address the poor risk assessment or inadequate datix & 72 hr reports.
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 **23/06/2023**. 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, the family of Mr Charles; the Care Quality Commission; The Nursing & Midwifery Council; the General Medical Council; the Metropolitan Police Service. I have also sent it to the local Director of Public Health who may find it useful or of interest. • Mr Charles' family. • The Care Quality Commission. • The Nursing and Midwifery Council • The General Medical Council • The Metropolitan Police Service • The local Director of Public Health 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 other 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.
9	**[DATE] 28/04/2023 [SIGNED BY CORONER]**