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. Chief Executive Officer Essex Partnership University NHS Foundation Trust** **2. Chief Executive Officer Essex County Council**
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 26 July 2022 an investigation was commenced into the death of MORGAN-ROSE HART aged 18. The investigation concluded at the end of the inquest on 1 December 2023. The conclusion of the jury inquest was 1a Hypoxic Ischaemic Brain Injury 1b Cardiac Arrest 1c Ligature Misadventure Contributed by Neglect Morgan-Rose Hart's transfer to adult services was not supported enough with a clear transfer to ease her anxieties and worries. From the transfer to Chelmer ward Morgan-Rose's medical history, diagnosis and triggers including her communication passport were not filtered down to staff who were tasked to providing her day-to-day care. Morgan-Rose's known triggers and change in behaviour were not observed or documented whilst she was presenting behaviours of her mental health deteriorating. For example, doing her make up, spending more time alone and losing weight. Observations mainly being completed via the Oxevision system apart from the level 3 observations. There was limited therapeutic engagements or attempts to engage with Morgan-Rose. Staff observations being falsified led to Morgan-Rose not being checked and she felt staff did not have time for her. On the day of the 6th July 2022, critical observations were missed, Oxevision alerts were muted or reset without the correct procedures being adhered to, contributed to Morgan-Rose being left unattended in her bathroom for approximately 50 minutes after the Oxevision red alert was reset on display 01, in this time she tied a ligature around her neck. Morgan-Rose expressed she did not want to die but was high risk of self-harm and had a history of ligaturing. It was also documented Morgan-Rose was

	known to mask her behaviours. When reduced to Level 2 and Level 1 observations the correct risk assessments including room checks were not completed. Resulting in restricted items being easily accessed. This increased the risk of self-harm. The failure of basic protocol and procedure documented by Essex Partnership University NHS Foundation Trust resulted in Morgan-Rose Hart dying by Misadventure Contributed by Neglect.
4	**CIRCUMSTANCES OF THE DEATH** Morgan Rose died on 12th July 2022 at the Princess Alexander Hospital, Hamstel Road, Harlow, Essex following being found unresponsive on the bathroom floor of her room. Morgan-Rose Hart was detained under section 3 of the Mental Health Act at the Derwent Centre on the female ward called Chelmer. Morgan-Rose had tied a ligature around her neck which resulted in a Cardiac Arrest and then Hypoxic Ischaemic Brain Injury. Morgan-Rose Hart was pronounced dead on the 12th July 2022 after brain stem testing confirmed Morgan-rose Hart had sustained Irreversible Brian Injury. On 6th July 2022 events contributed to Morgan-Rose's mental health deterioration. Morgan-Rose was not observed clinically since 14:06 and the time in between the last observation and when Morgan-Rose was discovered multiple failings occurred. These include non-clinical and clinical staff commenting on her appearance, a delivery of flowers triggering a response, observation Level 1 missed the following hour, as well as the consecutive hours observations also being incorrect and falsified. Other events during the day triggered an emotional response clinical staff reflecting unescorted leave and no therapeutic engagement was made to see if Morgan-Rose was okay. After the delivery of the flowers incorrectly delivered to Morgan-Rose. Morgan-Rose attempted to contact relatives to clarify who these were from as there was some confusion as to who the flowers were for. The flowers were not meant for Morgan-Rose. Whilst Morgan-Rose was in the bedroom multiple attempts were made to interact with the Oxevision system to check vital signs, although the system could not access this due to the tile being Amber stating that Morgan-Rose was in the bathroom. Regardless of the Oxevision no member of staff attempted a physical welfare check until she was discovered unresponsive on the bathroom floor, in the shower, fully clothes at 16:20:37, confirmed on CCTV records. Staff proceeded to perform CPR and resuscitation until paramedics arrived at 16:27. Morgan-rose was left unattended for approximately 50 minutes prior to being found with the ligature around her neck. Morgan's last physical check was at 14:06. Morgan-Rose had not had recorded observations for 2 hours and 14 minutes according to CCTV footage.
5	**<u>CORONER'S CONCERNS</u>** 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. –

Essex Partnership NHS Foundation Trust.

(1) The Trust investigation was materially incomplete and there was a lost an opportunity to:

a. Understand concerns of the Family

b. Acknowledge errors and learn lessons from the circumstances of the death. The Director of Operations and Matron informed the Trust Senior Management that the PSII Report had omissions. The Trust evidence was that it was an early adopter of the new NHS investigation process. The lead investigator did not report on material issues as to how Morgan-Rose was observed on the ward and the report was significantly delayed. Evidence was there was a pressure to sign the report off although it remained incomplete and did not contain a note about the limitations.

c.

d. Escalate concerns about staff observations - About 2 weeks after the death the Matron received a report that staff observations had not been appropriately conducted. This prompted a review of CCTV from the afternoon of Morgan-Rose's death. There was insufficient scrutiny of the CCTV that showed that multiple observations entries made on 6 July 2022 after 14:06 hours could not be correct.

e. Understand security issues on a locked mental health ward - It has not been possible to establish the identity of the person that reset the bathroom alert triggered for Morgan-Rose on 6 July 2022 at 15:31. The Trust does not have an accurate records of Trust staff pass allocation. The Trust investigation did not establish that staff borrowed each other's security passes. On the day of Morgan-Rose's death a visitor pass issued that had access to the nursing office. The Trust was unable to provide the identity of this person.

(2) There was a dispute in evidence over whether it was or was not permitted for patients to have belts on Chelmer Ward, that has not been resolved.

a. Morgan-Rose was on 1:1 observation due to her high risk of self-harm that including ligaturing and a belt was in her possession

b. The Responsible Clinician and a Ward Manager providing support to

staff gave evidence at that time that belts were not permitted

c. The Trust senior management stated that belts were permitted and referenced the policy. The Updated ward documentation 'Handover Checklist' approved in October 2023 contains belts on a list of prohibited items. The Trust has stated that this is not correct although this was part of the After-Action Review and is in current use.

(3) Escalation of risk – Morgan-Rose attempted to secure unescorted leave on the morning of her death, her Responsible Clinician had only authorised escorted leave. This was not escalated to the nurse in charge and the Responsible Clinician was not informed.

(4) Bathroom alerts – Evidence was heard that an Oxevision alert is triggered if a person is in the bathroom for more than 3 minutes and staff are required to complete an in-person check. Morgan-Rose was left in the bathroom unobserved for approximately 50 minutes. It was not clear from the evidence how the Trust proposes to ensure compliance in respect of this duty.

(5) Trust oversight of care – the quality of record keeping was acknowledged not to be appropriate by nurses and senior staff during evidence, yet had been signed off:

a. Observations sheets for vulnerable detained mental patients were signed off by nurses in charge as being appropriate despite an absence of any recorded therapeutic engagement

b. Omissions in the recording of food and fluid charts required by the Responsible Clinician for a patient who was losing weight with a diagnosis of Body Dysmorphic Disorder.

c. The Responsible Clinician's evidence was that the absence of appropriate food and fluid charts for other patients was an ongoing issue on Chelmer Ward that had been raised with nursing staff

(6) Staff entries in patient observations sheets should have given rise to a concern that some staff may have been using Oxevision not just as an adjunct to face-to-face observations, but instead of them. This remains a concern.

	Essex County Council (7) There is a significant shortfall of appropriate placements for people with Autism who have mental health and self-harm risks in Essex both inpatient and the community.
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 12 February 2024. 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) • [redacted] (Father) I have also sent it to Care Quality Commission who 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	S. M. Hayes **19 December 2023** **HM Area Coroner for Essex Sonia Hayes**