REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Chief Executive Officer Surrey and Borders Partnership NHS Foundation Trust**
1	**CORONER** I am Darren Stewart OBE, Assistant Coroner, for the Coroner Area of Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 10th June 2021 I commenced an investigation into the death of Larry Stephen SPRIGGS. The investigation concluded at the end of the inquest on 7th December 2022. The inquest was heard without a Jury. Mr. SPRIGGS died of: 1a. Multiple Injuries The jury returned the following narrative conclusion: Frimley Park (23rd May - 25th May) Mr Spriggs was admitted to Frimley Park hospital on the 23 rd May 2021 after attempting to commit suicide by overdosing [redacted]. He was assessed as suffering a mental health crisis and placed into a highrisk category. He was kept at Frimley Park Hospital until he was transferred to Farnham Road Hospital. Farnham Road (25th May - 27th May) Upon admission to Victoria ward at Farnham Road on the 25th May 2021 at 6:45pm, Mr Spriggs's risk was assessed as low, compared to the assessment of his risk at Frimley Park hospital as high. Upon clerking-in he presented as calm, regretful and rational, presenting as low risk to self with no suicidal ideation at the time. The reduction from a previously assessed level of high risk to low risk made a possible contribution to his death as this may have impacted the urgency of the risk management plan. The assessment did however recommend that 1-1 observations should continue. During the first night of his stay in Farnham Road Hospital, Mr Spriggs attempted to self-discharge in the early hours of the morning due to high dissatisfaction of the room, isolation and observation regime. Mr Spriggs was persuaded to remain on the ward by staff.

The consultant psychiatrist on the ward made a preliminary diagnosis for Mr Spriggs of an acute stress reaction, he noted that Mr Spriggs displayed no symptoms to have reached the threshold for pathological mental illness. The consultant psychiatrist did note that Mr Spriggs displayed fluctuating levels of anxiety from the collateral history. The consultant psychiatrist prescribed no anti-anxiety medication at this time and the failure to do so possibly contributed to Mr Spriggs death.

Mr Spriggs was offered anti-hypertension medication following high blood pressure readings on the 26th May 2021 but turned it down. On the 27th May 2021 he decided to proceed with taking this medication when offered again.

The decision to reduce Mr Spriggs observations from 1-1 to intermittent was made on the 26th May 2021 following assessment. The reduction in observations to intermittent made a material contribution to Mr Spriggs death.

Mr Spriggs was not expecting the environment he was placed into (both the setup of his room and the isolation period which was policy at the time for Covid-19) this led to a higher state of anxiety, reflected in the distressed texts sent to his partner.

His partner received additional distressed texts from Mr Spriggs on the 26th May 2021, stating "get me out of here" and "it feels like a prison" and "there is something in my tea".

Following a conversation between a member of staff and Mr Spriggs partner, the details of these texts were recorded on Mr Spriggs records. Staff on the following shift failed to make themselves aware of this important information. This failure made a material contribution to Mr Spriggs death.

27th May

On the morning of the 27 th May 2021, during a review of his blood test results Mr Spriggs was offered anti-hypertensive medication, vitamin D tablets and sleeping medication, which he was then willing to take. Mr Spriggs had reported to the doctor that his room and the isolation was causing him a lack of sleep and that he was not feeling very well.

On the morning of the 27th May 2021— Mr Spriggs was in communication with his partner still telling her that he wanted to leave but that he had to call her back as staff members had entered his room for observations.

At 9:48pm on the 27th May 2021, Mr Spriggs was given his medication that had been offered earlier in the day.

At approximately 9:52pm on the 27th May 2021, the CCTV picks up the last movement from inside Mr Spriggs room.

Between 9:54pm -9:57pm on the 27th May 2021, Mr Spriggs exited the window and fell to the ground which was recorded on CCTV.

[redacted]

Observations on the night of the 27th May 2021

	On the evening of Mr Spriggs death, the observations that were carried out on Mr Spriggs were inadequate. There were inconsistencies in the quality of observations, the observation sheet was pre-populated with observation timings, the timing of observations were not random, inaccurate engagement codes were entered onto the observation sheet and conversations with Mr Spriggs did not take place, these failures made a material contribution to Mr Spriggs death. Following from these inadequate observations, the handover to the next HCA did not take place verbally and the inaccurate observation sheet was left in the lounge on the ward, instead of in the nurses station. Induction training for staff on the evening of 27th May 2021 was inadequate and failed to explain what an observation should include and how they were to be carried out. The second sheet of the formal induction checklist document for the evening of the 27th May 2021 was not signed by the inductor. The effect of these failures meant that arrangements to manage the observation regime were inadequate and made a material contribution to Mr Spriggs death. The death was contributed to by Neglect. The death was caused or more than minimally contributed to by the failure on the part of Surrey and Borders Partnership NHS Foundation Trust to ensure the adequate implementation of intermittent observations in relation to Mr Spriggs's care. Larry Stephen Spriggs died as a result of misadventure.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are recorded in the Jury's Narrative Conclusion.

5. **CORONER'S CONCERNS**

During the course of the inquest the evidence revealed matters giving rise to concern.

The **MATTERS OF CONCERN** are as follows:

a. The adequacy of arrangements in place at Farnham Road Hospital to assess and manage inpatients risk.

b. Use (or non-use) of anti-anxiety medication in relation to the support of Mr. SPRIGGS' symptoms.

c. Passage of information between staff concerning patients care and treatment.

d. The adequacy of arrangements to manage and implement the intermittent observation regime at Farnham Road Hospital.

e. Processes for the management of incidents at Farnham Road Hospital such as those on the 27th May 2021 when Mr. SPRIGGS fell from the window of his room.

I received further evidence orally and in writing from the Interested Persons' subsequent to the completion of the Inquest in relation to these concerns.

This evidence included a response from Surrey and Borders Partnership NHS Foundation Trust (SABP). The Trust outlined a number of prospective measures it is either considering the implementation of, or has plans for their implementation.

These measures included:

1. The Trust was reviewing its risk assessment policy, including a new risk assessment tool.

2. Training and induction packages have been reviewed and revised for staff, including junior doctors and temporary ward staff.

3. A draft Care Planning Principles Policy has been developed.

4. The 10 Key Steps to Safety handover document used by the Trust has been reviewed and revised.

5. The Observation Competency Checklist has been changed following review.

6. The Trust is implementing the Systems Engineering Initiative for Patient Safety (SEIPS).

It was explained to the court that these measures should be seen in the context of wider cultural change management being undertaken by the Trust at Farnham Road Hospital.

	I have taken account of the measures, many of which are prospective, as outlined by SABP. However, I remain concerned in relation to the matters identified at sub-paragraphs a to d (above). 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: Evidence of the cultural change in the delivery of care and treatment of patients, accepted by the Trust as required, was not provided to the court; either in the form of a plan to bring such change about, or evidence that such change has otherwise occurred. The adequacy of arrangements in place at Farnham Road Hospital to assess and manage inpatients risk, including the prescription of anti-anxiety medication. Passage of information between staff concerning patients care and treatment. The adequacy of arrangements to manage and implement intermittent observation at Farnham Road Hospital.
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 16th February 2024. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting outthe 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 namely: a. Family of Larry Stephen SPRIGGS b. Surrey and Borders Partnership NHS Foundation Trust 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 ituseful 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	**22nd December 2023** **Darren Stewart OBE**