REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Rt Hon Victoria Atkins, Department of Health And Social Care, 39 Victoria Street, London, SW1H 0EU**
	CORONER I am Joanne Kearsley, Senior Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 17th December 2020, I commenced an investigation into the death of Charlie Millers. Charlie died on the 7th December 2020. The investigation concluded on the 25th April 2024. The medical cause of death was confirmed as 1a) Hypoxic Brain Injury 2) ADHD, Emotionally Unstable Personality Disorder, Mixed Conduct Disorder and Autism. A jury recorded a narrative conclusion.
4	**CIRCUMSTANCES OF DEATH** On the 2nd December 2020 Charlie was detained under Section 2 Mental Health Act 1983 on Junction 17 the Child Adolescent Mental Health unit at Prestwich Hospital. At 22:31 hours he was found in his room having tied a ligature. He died 5 days later in Salford Royal Hospital. This was Charlie's third inpatient admission since July 2020. During his most recent admission it was accepted that his self harming behaviour had escalated in frequency and severity. It was recognised by his clinical team that being an inpatient was not assisting Charlie. Charlie had returned from home leave at 19:45 hours on the 2nd December, it was known and recognised that return from home leave was a time when Charlie would ligature. Charlie was therefore on 1:5 minute observations with increased 1-1 support if he required it. At the time the Trust Observation Policy allowed two forms to be used in order to conduct 1:5 observations: - One form ensured the staff member recorded details every 5 mins. None of these forms were completed on the evening of the 2nd December for Charlie. Indeed for his entire three admissions, spanning almost three months, only one such form was located. - A second form meant staff only had to sign once at the end of the period of observations ie hourly. ("Level 2 hourly form") In addition there was a separate Level 3 Observation 1:15 minute form which was completed for all young persons who as a matter of routine were checked every 15 minutes. The court heard evidence that at the commencement of each shift the nurse in charge allocated staff members their roles for the shift. This would change hourly and should be detailed on the allocation sheet. In addition the court heard that the staff member completing 1:5 minute checks on a young person would be different from the person completing the 1:15 minute checks on all the young people. On the 2nd December Staff the ***allocation sheet*** shows; 8-9pm – No-one allocated to Charlie's 1:5 obs. HB allocated to 1:15 obs for everyone.

9-10pm Staff Member HB allocated to Charlie's 1:5 obs. D allocated to 1:15 obs for everyone

10-11pm Staff Member D (female) allocated to Charlie's 1:5 obs. M allocated to 1:15 obs for everyone.

Level 3 1:15 Form

Between 9pm – 9.45 D signs every 15 minutes to say 1:15 obs completed on all yps

10pm -10.30 staff HO signs to say 1:15 obs completed on all yps.

Level 2 Hourly Form for Charlie's 1:5 observations

8-9pm signed by D – D told the court he signed this form at 8pm but had not done the observations, the space was blank and he used more space for his entry at 9pm

9-10pm signed by D

10-11pm signed by HO (Charlie was found at 22:31 hours)

The evidence therefore suggests that if Charlie's 1:5 observations were being undertaken from 9pm onwards, they were being undertaken by the same member of staff who was undertaking 1:15 minute checks on the other young persons.

His final ligature was the fourth one Charlie had tied from returning back to the ward at 7.45pm.

Previous Observation Issues

- **Death of RT**

In October 2020 another young person had died on a different ward at this site. During the course of that Inquest it was found observations were not being conducted appropriately in that staff were not completing observation checks. As a result, management were supposed to be auditing observation documentation daily. Albeit it was acknowledged audits of paperwork would not evidence if staff were falsifying the documentation ie competing the paperwork but not doing the check. A regulation 28 report was issued following this Inquest.

- **Death of AS**

In June 2021 another young person died on another ward in Junction 17. At the time this individual was on 1:5 minute observations. A similar regulation 28 report was issued in respect of the 1:5 documentation and the evidence to the court at that stage was that there was no other 1:5 observation record other than the Level 2 hourly form. The court was concerned as there was no record to say 1:5 checks were done. In light of the evidence in Charlie's case this appears inaccurate. At this time the audit by senior managers, which had been put in place in October 2020 should have been ongoing

Investigations and Reviews

1. *Greater Manchester Mental Health Trust Root Cause Serious Incident Reports.* All three deaths were reviewed internally by GMMH. In respect of the investigation into Charlie's death the review was completed by clinical team members. Whilst some inhouse training is provided as to how to conduct reviews, they are not trained investigators. The Inquest ascertained that not all the staff who were on duty on the night Charlie ligatured were spoken to or asked for statements. The findings of the investigation relied on the completed observation sheets to reach a finding that i) Charlie's 1:5 observations were conducted (ii) that they were conducted by the staff member who was already completing 1:15 obs. **There was no questioning as to the accuracy of this or how this was possible. Nor whether this was in line with Trust policy, nor whether this was a safe practice for all the young persons on the ward. It did not consider whether the senior manager audits were being conducted.**

2. Following the deaths of Charlie and the other young persons *NHS England commissioned an Independent desktop review* of the three cases. **This review had access to the Trust's Root Cause Analysis Serious Investigation Reports and simply relied on their findings**. This review did not highlight any concerns.

3. **Greater Manchester Police** – In January 2023 the Inquest into Charlie's death was adjourned following identification of the 1:5 observation sheet detailing an entry for every 5 minutes. GMP were asked to review this case to consider if there were potentially any individual criminal offences or corporate offences. GMP reported that there was no evidence of any criminal offences. At this time GMP were also considering wider issues relating to concerns raised from the BBC Panorama programme about the Edenfield unit which is based on this site. GMP also investigated the other two deaths.

   Not all the members of staff who were on duty that night were spoken to. Three members of staff were interviewed. D and HO confirmed they were doing the 5 minute observations as they signed the hourly sheet. This investigation does not appeared to have considered how this was possible if the staff were conducting 1:15 checks on the other young people. Nor whether this was in line with Trust policies or whether it made for a safe environment for all the young persons.

4. **Independent Review of Greater Manchester Mental Health NHS Foundation Trust December 2023 by Professor Oliver Shanley**. This report was commissioned by NHS England following the BBC programme which aired in September 2022. [redacted] gave evidence to the court in Charlie's Inquest. He told the court that as part of his investigation in September 2023 his team requested copies of the audits of observations by senior managers. He requested them from June, July and August 2023. He was subsequently advised that it had been discovered by the Trust that there, "was *no formal system and process in the form of governance and the application of this audit was at ward level.*" Evidence showed in July 2021 the audit was completed 17 times out of 28 (61%0. In 2022 it was completed 25 times out of 52 (48%) and in 2023 it was completed 9 times out of 36 (25%). In conclusion Professor Shanley found (para 9.103):

   "*The Trust reviewed and ratified their Therapeutic Engagement and Observation Policy in September 2023. However, it is noteworthy that it doesn't address the original problem. There was no issue with the policy and the Trust was able to demonstrate that a number of staff working on that ward understood the policy and its implementation, but for reasons that are still not fully understood, they failed to follow its guidance.*"

5. No investigation was conducted by the Care Quality Commission who were aware of Charlie's death.

6. No investigation was conducted by the Health Services Investigations Body and it does not appear they were made aware of this case. Without oversight of all cases and issues it is not clear whether the report of Charlie's death in isolation would meet their criteria.

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. Deaths of patients detained under the Mental Health Act 1983 are not subject to any independent investigation in the same way as deaths in police custody (Independent Office Police Complaints) or in Prison (Prison and Probation Ombudsman). As a result, investigations are not effective, no single body has oversight of previous concerns and how these were going to be rectified by the organisation. Therefore critical learning and evidence is being lost which may prevent future deaths.

2. In addition the Investigations which are currently being undertaken are ineffective either due to a lack of trained, investigators who conduct internal reviews or a lack of understanding of complex health processes and procedures.

6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 **24th June 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 namely:- - Family of Charlie Millers - Greater Manchester Mental Health Trust - NHS England - Care Quality Commission - Trafford Children's Services - Trafford Community CAMHS Service As they are referenced in this Regulation 28 PFD I have also forwarded the same to Greater Manchester Police and the Health Services Safety Investigations Body 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 from. 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	Date: 26th April 2024 Signed: