

## Regulation 28: Prevention of Future Deaths report

Anna Vivien Elliott (died 24 November 2021)

	<p><b>THIS REPORT IS BEING SENT TO:</b></p> <p><b>1. East London Foundation Trust (ELFT)</b></p>
1	<p><b>CORONER</b></p> <p>I am: Melanie Sarah Lee Assistant Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 30 November 2011 an investigation was commenced into the death of Anna Vivien Elliott aged 26 years. The investigation concluded at the end of the inquest on 20 June 2024. The jury made a determination at inquest Anna suffered from severe and recurrent depression and took her own life. They also found that her death was contributed to by neglect.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Anna had severe recurrent depression with psychotic features and autism spectrum disorder. During an inpatient mental health admission in June and July 2021, Anna had benefitted from ECT treatment. A further course of ECT was arrange for Anna as an outpatient but this was postponed on 22 November 2021. This had a negative effect on Anna, including a deterioration of her mental state.</p> <p>On 23 November 2021 Anna was detained under s.2 of the Mental Health Act due to having thoughts and plans to end her life. She was</p>

	<p>transferred to Roman Ward at the Mile End Hospital in the early hours of 24 November.</p> <p>In the afternoon of 24 November 2021 Anna was found with a non-fixed ligature whilst on general observations. Staff risk assessed her, placed her on intermittent 15 minute observations and put in place a safety plan which included locking Anna's bedroom to ensure she spent the day in communal areas. The safety plan meant in practical terms that she was being observed most, if not all of the time, by staff.</p> <p>The jury found that there was an inadequate handover from day to night shift. There were also inadequate staffing levels on the night shift across the mental health unit, including Roman Ward. One of the support workers allocated to undertake safe and supportive observations on Roman Ward left to attend two emergency calls on other wards. Her colleagues were not aware that she had left the ward. This resulted in a failure of staff to undertake Anna's observations between 9.03pm and 9.48pm and 9.48pm and 10.58pm. However, the observation record was filled out to record that the observations had been conducted.</p> <p>A decision was made to let Anna into her room at 9.03pm. The jury found that there was inadequate consideration given to changing her safety plan including no conversations had, no questions asked about Anna's mood and no risk assessment undertaken. Despite the planned continuation of 15 minute intermittent observations from day to night shift, the change in her safety plan meant there was a change in how Anna was to be observed during the night shift. This was inadequately appreciated, inadequately considered and not risk assessed.</p> <p>Anna was found in her room at 10:58pm with non-fixed ligatures made from nightwear and contraband items. She was pronounced deceased at 11:57pm.</p> <p>During the inquest ELFT made candid and helpful admissions.</p>
5	<p><b>CORONER'S CONCERNS</b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows.</p> <p><b>Concern 1</b></p> <p>There were issues with record keeping across the board. Including, a telephone call from Anna's mother reporting concerning messages was not recorded or passed on; an entry relating to a different patient was</p>

recorded in Anna's records; staff were sharing log on details or not logging off from their account (also raising data protection concerns); and the written handover document was inadequate, failing to record vital information.

### **Concern 2**

The Trust's policy is very clear on what should be recorded on the safe and supportive observation charts. In addition, all of the witnesses could explain in evidence, the expectation and what good practice looks like. However, only one staff member's entries met this expectation. All of the other entries that I was taken to simply recorded Anna's location at the time of the observation. I heard evidence that observation records are audited for quality and entries raised with staff if they do not meet expectations. However, this process of auditing was in place at the time of Anna's death and the observation entries of the senior nurses responsible for that auditing were of the same poor quality.

### **Concern 3**


In Anna's case, safe and supportive observations were missed. This is, at least, in part due to high acuity on the unit as a whole on the night of Anna's death, a support worker undertaking those observations being called away to an emergency and her colleagues reporting being unaware that she had left the ward. I heard evidence about steps that have been put in place to prevent observations being missed but the data provided by the Trust appeared to show that missed observations are rising and not decreasing. However, the data provided was out of date and the PFD witness was unable to interpret what was provided. I heard evidence about a strong focus on safety, openness and honesty following Anna's death. I am therefore unclear whether the data reflects a true rise in missed observations or whether it is the result of more honest reporting of missed observations by staff on the ground.

### **Concern 4**

In Anna's case, observation records were backfilled despite the observations not having been conducted. All of the witnesses who gave evidence had received training, were aware of a previous PFD on missed and falsified observations, could tell me the purpose and importance of the observations, knew that observations should not be falsified and knew that if observations were missed, this should be reported that to the nurse in charge. I was also provided with screenshots of training which included a message from the Chief Nurse appearing to be dated May 2024 which refer to "an increase in occasions where observation records have not been completed but records falsified to reflect that they had been done". As the spot checks described to me only look at the quality and timings of the written observations, I am not reassured that records are not still being falsified or about how this is being identified and addressed.

### **Concern 5**

	<p>A safety plan had been agreed with Anna and put in place in the afternoon of 24 November 2021. This worked well and was a good example of staff thinking about Anna's safety and the best strategy in the context of least restrictive practice. However, during the night shift, that safety plan was ended without a formal (or any adequate) risk assessment taking place. In accordance with the Trust's policy, safe and supportive observation levels cannot be decreased without the input of a doctor. I remain unclear whether the same applies to other measures contained in safety plans and the PFD witness was unable to confirm the position.</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion, action should be taken to prevent future deaths and I believe that your organisations have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 12 September 2024. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the following.</p> <ul style="list-style-type: none"> <li>• Family of Anna Elliott</li> <li>• Her Honour Judge Alexia Durran, the Chief Coroner of England &amp; Wales</li> <li>• Nursing and Midwifery Council</li> <li>• CQC</li> </ul> <p>The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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.</p>
9	<p><b>DATE</b> <span style="float: right;"><b>SIGNED BY ASSISTANT CORONER</b></span></p>

	18 July 2024	
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