REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **[redacted], Director Adult Social Care Mid Alliance Safeguarding, MCA and DoLs, Essex County Council, County Hall, Chelmsford, Essex, CM1 1QH**
1	**CORONER** I am Sean Horstead, 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 24th November 2023 I commenced an investigation into the death of Linda Marilyn Sitch, aged 75 years. The investigation concluded at the end of a three day inquest on the 3rd April 2025. Mrs Sitch died at Broomfield Hospital, Court Road, Chelmsford, Essex. The medical cause of death was confirmed as: *1a* [redacted]*overdose*. My Narrative Conclusion confirmed that Mrs Sitch (hereafter 'Linda') had taken her own life on a background of the impact upon her emotional and mental health well-being of looking after her elderly husband (with whom she had shared a long and happy marriage) and who, himself, suffered from significant on-going mental and physical health problems. The Narrative Conclusion included a summary chronology of the involvement of Adult Social Care with Linda over the last six weeks or so of life. During my summing-up, when providing my findings and determinations, I made it clear that the failings identified in the course of the inquest, although very *possibly* contributed to the death, I did not find, in the specific circumstances, that they were *probably* more than minimally causative of the death.
4	**CIRCUMSTANCES OF THE DEATH** Linda's husband had been suffering from significant physical and mental health challenges for more than a year or so prior to her death; the impact of aspects of his initial presentation deeply affected Linda, to the extent that she attempted to

	take her own life on three occasions in October 2022. This led to her admission as a voluntary in-patient at a Mental Health facility under the care of Essex Partnership University NHS Foundation Trust (EPUT). She received a diagnosis of an 'Adjustment Disorder'. She was discharged to the care of the Community Mental Health Team in February 2023 and remained largely stable in her presentation through until the late summer of 2023. Her husband, having himself been detained under the provisions of the Mental Health Act 1983, was discharged back to the family home in June 2023. On 29th September 2023 Linda's husband's EPUT Care Coordinator raised an Adult Safeguarding (ASG) concern with Essex County Council's Adult Social Care (ASC) regarding Linda's potential (unintentional) maladministration of her husband's medication. The referral contained details of Linda's own history of overdosing and the concerns of family members relating to Linda's presentation and her ability to care for her husband. *By the time of her death on 11th November, no action had been taken by ASC regarding this Safeguarding referral.* On the 2nd October 2023 a further referral was received from the same CPN requesting a Care Act (2014) Carer's Assessment for Linda. The referral again informed ASC that Linda was struggling with caring for John. Without apparently considering the ASG referral, this further referral was subsequently erroneously downgraded by the Community Team Manager from Priority 1 (requiring an immediate response) to Priority 2 (response within 28 days). The rationale for so doing was not recorded, as it should have been. *By the time of her death no further action had been taken by ASC regarding the referral for a carer's assessment.* On 16th October further contact was made by Linda's daughter chasing-up the 2nd October referral, re-emphasising the escalating and serious family concerns regarding Linda's presentation, reiterating that Linda had attempted suicide the previous year and expressing concerns that Linda was exceptionally stressed and needed a break. As a consequence of (admitted) human error this information was not acted upon. Had it been reviewed the priority level would have been changed back to Priority 1 and there would have been immediate action, within 24 to 48 hours. Options would likely have included, *inter alia*, interim carers or residential respite. This would also have been an opportunity to establish if Linda had need in her own right. *By the time of her death no further action had been taken by ASC regarding this additional contact*. On 7th November Linda's husband was admitted to Hospital for a medical issue; he was due to be discharged the following week. Prior to his discharge home, Linda took her own life.
5	**CORONER'S CONCERNS** During the inquest the evidence revealed matters giving rise to concern and 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. –

a. Although not determined to be probably causative of the death, by the date of Linda's death *ASC had failed to respond substantively or at all* to the Adult Safeguarding Referral dated 29th September 2023; the referral for a Carer's Assessment for Linda herself, received by ASC on 2nd October 2023; the concerns reiterated by Linda's family when chasing the 2nd October referral on 16th October 2023. These failures were explained as 'human error'.

b. The oral evidence of the ASC Service Manager at the inquest (though not mentioned in her statement prepared for the purposes of the inquest), confirmed that the Team Manager responsible for downgrading the Priority 1 status of the carer's assessment referral on 2nd October to Priority 2, without recording a rationale, had likely done so without undertaking the required consideration of either the readily available ASG referral of the 29th September, or the Mental Health Act assessment of Linda herself from the previous year. She agreed that, had an estimated *"ten minute"* review of the *"slim files"* for both Linda and her husband been undertaken, as should have happened, the Priority level *could not and would not have been reasonably downgraded*. She accordingly accepted that, in fact, (and contrary to her witness statement) the decision to downgrade to Priority 2 was capable of being determined, by her as an ASC Service Manager, to be 'inappropriate'.

c. Nonetheless, the ASC Service Manager remained personally *"reassured"* that a change in Team Manager - along with reminders to personnel of best practice - had sufficiently addressed issues identified by the inquest proceedings.

d. In contrast to this view, I remain concerned that ASC continues to lack a robust system to ensure sufficiently rigorous oversight, including active auditing, capable of identifying the kind of sub-optimal managerial level performance as has been brought to the fore in this case. A change in personnel and moves towards *"embedding best practice"* do not, in my opinion, sufficiently address this systemic lacuna given that the effectiveness of such changes will still rely very substantially upon the performance of any Team Manager and/or a Deputy Team Manager. There appears to me to be a continuing lack of robust Service level oversight of those managers themselves, (including the appropriateness of their decision making), absent which any sub-optimal performance by said managers may well not be identified.

e. Absent a sufficiently robust system for providing oversight and identifying and significantly mitigating (if not entirely removing) such individual human error, alongside, for example, the inclusion of simple auditable check lists of matters to be accessed, reviewed and documented whenever a referral is received, then there is a continuing risk of urgent future referrals being inappropriately graded as Priority 2 (and/or being downgraded from Priority 1) without the requisite thorough and

	professional review, adequately documented, being undertaken. This gives rise to a concomitant risk of future deaths.
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 Wednesday 12th June 2025. 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 and others: **The Family of Linda Sitch** **Essex Partnership NHS Foundation Trust** **Essex Safeguarding Adult Board and ESAB SAR Panel Independent Chair** 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 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	 **HM Area Coroner for Essex Sean Horstead** **17.04.2025**