

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: ██████████, CEO Essex Partnership University NHS Foundation Trust
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 5th January 2022 I commenced an investigation into the death of Stephen John Neville, aged 68 years. The investigation concluded at the end of the 9-day article 2 (non-jury) inquest on the 23rd October 2025. The Conclusion of the inquest was a <u>Short Form Conclusion</u> of 'Suicide contributed to by Neglect' in conjunction with an expanded <u>Narrative Conclusion</u> which identified a series of serious failings cumulatively amounting to a gross failure to provide Stephen Neville, a person in a dependent position, with basic medical care. Steve, as he was known, had taken his own life by hanging ██████████ whilst an informal inpatient.
4	CIRCUMSTANCES OF THE DEATH On a background of diagnoses of severe (treatment resistant) depression with anxiety and agitation and repeated attempts at suicide and self-harm, with recent and on-going further deterioration in his mental state, Steve was admitted as an informal patient to Beech (Older Adult) Ward at Rochford Hospital run by Essex Partnership University NHS Foundation Trust (EPUT) on 16th December 2021 for planned Electro Convulsive Therapy (ECT). He had been under the care of the Older Adult Community Mental Health Team (OACMHT). His direct admission had bi-passed the Trust's usual referral, gatekeeping and bed management processes, contrary to Trust policy. An Associate Specialist Psychiatrist (ASP), undertook Steve's clinical review on

the 17th December. She was unaware that Steve had been prescribed daily Lorazepam in the community for some 14 months (alongside antidepressant medication). This critical information had not been communicated to her by the OACMHT and neither had she reviewed, as she accepted she could and should have, the available medical records to obtain this information.

In summary form only, the following findings and determinations informed the Conclusion:

- failures to identify and communicate up-to date risk assessments from (and between) mental health teams in the community and the in-patient team, including but not limited to the very extended duration of the prescribing of Lorazepam prior to admission;
- upon admission, staff failed to appreciate Steve's longitudinal risk (focussing only on the admission for ECT) and failed to engage with family members to seek further information relevant to Steve's present risk;
- the doctor conducting the medical review on the 17th December failed to read and review readily available medical records prior to making significant decisions regarding medication changes and therefore failed to consider the likely impact on subsequent risk management of such a sudden change to medication;
- the reviewing doctor failed to discuss and explain the abrupt medication changes to Steve and/or his family and failed to formally undertake a risk review or convene an MDT for that purpose;
- the reviewing doctor failed to ensure that the nursing (and therefore support worker) staff were made aware of the abrupt medication changes and the potential impact on Steve's risk and, consequently, their heightened role in risk management through (on-going) therapeutic observation and engagement;
- EPUT staff failed to appropriately *undertake and document* Level 2 therapeutic observation and engagement as per Trust policy;
- EPUT failed to ensure there was in place (then and now) an appropriate and effective auditing and quality assurance process to ensure the *nature and quality* of the therapeutic observation and engagement undertaken by staff was consistent with Trust policy;
- a failure on the part of the nurse administering medication on the morning of the death to confirm to Steve (who was expecting to receive Lorazepam upon which he, by that stage, depended), that whilst his prescription of Lorazepam had been stopped (until then unbeknownst to him), PRN Lorazepam, albeit at a much-reduced level, (alongside Promethazine PRN) was potentially available;
- a failure to appropriately manage the unlocked shower room, [REDACTED] in which Steve died, by failing to attempt to mitigate the clear risks that his unsupervised access to this room represented. The Trust 'plan' for the mitigation of this risk was limited to (a) making all staff aware of the [REDACTED] and (b) undertaking some form of individualised risk assessments and putting in place risk mitigation for individual patients.

	There was a failure to mitigate that risk by failing to implement any 'individualised' measures relevant to managing Steve's specific risk, for example by increasing his observation levels and/or removing the cord from his tracksuit bottoms that he had been allowed to retain, including after the abrupt changes to his medication.
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. There was a failure on the part of EPUT nursing and (particularly) support staff to appropriately <i>undertake and record</i> the required therapeutic engagement and interaction observations. Members of support staff demonstrably misunderstood (and appear to still misunderstand) the nature and purpose of Level 2 '<i>intermittent</i>' (4 to 5 times) hourly observations, apparently routinely conducting such observations every 15 minutes on the hour, the quarter past and so on. Whilst the observations, when made, recorded the location of the patient and (very occasionally) noted what the patient may be doing, nothing was recorded in respect of an interaction or therapeutic engagement, as required by Trust policy. Such a lack of understanding of the basic role of the support worker and/or nursing staff in undertaking such critically important roles disclosed an (on-going) deficit in training. 2. Further, the clear evidence also disclosed an <i>on-going</i> failure in the quality assurance and auditing processes deployed by EPUT. A purported weekly quality assurance check being undertaken by the Ward Manager in December 2021, which claimed "<i>an audit score of 100%</i>", was entirely at odds with the evidence at inquest which revealed repeated and significant inadequacies in the nature and quality of the observations undertaken and recorded. 3. Of even greater concern is that even after the move from paper to electronic observation records the same Beech Ward Manager (then and now) stated in evidence: "<i>I have no audit tool I am not confident that the audits are accurate and complete now ... there is no audit process in place to check the quality of observation and engagement documentation.</i>" 4. The Deputy Director of Quality and Safety (Inpatient and Urgent Care) recognised in her written and oral evidence that the available free text box now included on the electronic version of the records relating to observation and engagement is "<i>not a mandatory field</i>" in the recording

	process and that: <i>“it appears that at some point the Tendable audits were amended to omit the audits of the quality and nature of the observation records.”</i> 5. It remains unclear how (or why) this came about, and I am very concerned that the apparent reliance on staff supervision (as per paragraph 7.1 of the <i>Therapeutic Engagement and Supportive Observation Clinical Guideline (Inpatients)</i>) and staff handovers to rigorously audit the nature and quality of the conduct and recording of therapeutic engagement and supportive observations remains a wholly inadequate mechanism for the purposes of achieving appropriate qualitative compliance monitoring. 6. The lacuna identified above gives rise to a real concern regarding the robustness of EPUT quality assurance and auditing processes generally, and particularly in the context of the on-going issues relating to the nature and quality of the conduct by EPUT staff of such critically important observations including the essential therapeutic engagements and interactions, with highly vulnerable inpatients at risk of suicide. This is a concern, I am told, also shared by the Deputy Director quoted above.
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 19th December 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: • <i>The Family of the deceased.</i> • <i>NICHE Health & Social Care Consulting, who undertook the independent review of this death.</i>

	• <i>The CQC.</i> 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. She 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	24.10.2025 HM Area Coroner for Essex Sean Horstead