REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive of Essex Partnership University NHS Trust**
1	**CORONER** I am Sonia Hayes, 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 23 April 2021, an investigation was commenced into the death of Elise Kay Louise SEBASTIAN, AGE 16. The investigation concluded at the end of the inquest on 27 May 2025. The conclusion of the inquest was 1(a) Hypoxic Ischaemic Brain Injury, 1 (b) Cardiac Arrest, 1 (c) Compression of the Neck by Ligature We the jury, unanimously agree that Elise's death could have been prevented or her life prolonged if not for multiple failings in her care whilst at St. Aubyn's. We found two main factors that probably caused her death; the first being poorly administered observations due to poor staffing levels and falsified information on observation forms. The second being Elise being able to gain access to her room and her observation level in an isolated area not being considered, which directly led to Elise tying the fatal ligature. The evidence does show that Elise's death was contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** On 17th April 2021 Elise Kay Louise Sebastian tied a fatal ligature in her room on Longview Ward at St. Aubyn's Centre, after which she was taken to Colchester General Hospital where she died two days later.

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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. Mental Health Trust Staff on Longfield Ward:

    a. Elise was neurodiverse and staff were not trained in Autism

    b. were inexperienced. The majority were new bank and agency staff with limited experience working with detained children, and this matter had been raised by the Care Quality Commission about other Trust services in January 2021.

    c. Did not have sufficient staffing to conduct observations required by the doctors for patients on the ward. This was known to the mental health Trust management and had been raised by the ward manager. During the time of Elise's admission, the staff member allocated for observations for patients was required to conduct approximately 66 observations within an hour. This was not logistically possible. Management knew that staffing allocation on Longview Ward was not sufficient to conduct the required levels of observations to keep the patients safe. Evidence was heard during the inquest that there are still observations that are not being conducted either as required or at all within the Trust and remains an ongoing concern. Datix reporting incidents are not always raised.

    d. The mental health Trust implemented a system called Oxevision with a Project Board to assist with the planning and roll out of the new system. There were difficulties with the roll out on St.Aubyns ward who were part of the pilot, due to WiFi coverage and the Oxevision system not operating correctly.

    e. The clinical management at the Trust Project Board meeting overseeing the roll out for Oxevision, required that ward staff implement a procedure where the Oxevision fixed monitor in the ward office be observed

by a member of staff whilst the WiFi problem was resolved. This did not happen on Longview Ward.

f. The Trust Project Group had reports that WiFi was not working and any issues were required to be reported as incident reports on Datix forms but these were not being completed. The Trust Project Board did not question why they were not receiving the Datix forms with the known issues. There was no oversight of what was required to ensure that the roll-out was operating appropriately and/or what the Project Board expected in the interim whilst the WiFi difficulties were being investigated.

g. Not all the Trust staff on the ward were trained to use the Oxevision System.

h. There was disputed evidence about the volume on the fixed terminal for Oxevision in the office about whether the alert volume could be turned down or 'muted'. It was established that there was an incident unrelated to Elise's death where a doctor did turn this volume down on the ward.

2. Elise's medication changes whilst in mental health hospital were not correctly entered onto the medication chart:

    a. Elise asked for changes to her medication and then reported that these changes were not therapeutic. It was agreed with her consultant that her previous regime would be implemented. The medication was crossed out and removed from the prescription chart. Sertraline 200mg was re-prescribed by the consultant but not entered onto the medication chart and not administered.

    b. Nursing staff did not query the sudden cessation of medication for treating mental health with no replacement or explanation given. Elise suffered a significant deterioration in her mental health during this time, the frequency and severity of ligatures increased, and Elise had to be placed under section 3 Mental Health Act.

    c. There was no pharmacist scrutiny just prior to the Bank Holiday and the medication error was only noted

when questioned by Elise's family when she went on home leave.

3. There was poor communication between ward staff and vital information about self-harm and ligaturing was not handed over on shift change. It was undisputed that Elise tied 12 Ligatures between 7th and 14th April and [redacted] on 15 April. The Datix incident recording gave minimal details and only the ligatures from the 13th and 14th were recorded on the whiteboard in the nurse's office.

4. Mental Health Trust staff falsified Elise's observation records and this was not identified by the Trust post-death investigation despite the availability of timings from Oxevision imaging. This matter arose in an inquest that significantly post-dated Elise's death and there is concern that lessons had not been learned. The Trust internal investigation does not refer to this and these matters are arising with scrutiny within the inquest hearing.

5. The observation level for each young person is decided by the medical staff at the Trust and can be altered dependant on the patient's risk level. The Trust Policy had a protocol on how observations should be conducted. All observations should be recorded by the staff on formal observation sheets. There were sheets for Level 1 and another sheet for the levels 2,3 & 4. Risk assessments were incomplete and not all ligatures were included The entries in the records were not all consistent, some contradicted others and this included the levels of observations required to keep Elise safe on the observation charts that were required to be completed. This was confusing and remains a concern as these are entries made by qualified Trust staff who have received training in observations. During the Trust internal investigation after Elise's death, the investigator visited the ward and found observations were not being conducted in accordance with the Trust Policy.

6. Detained patients including Elise were not kept under observations by trained staff and mealtimes were chaotic with patients moving between areas without the required supervision. On 17 April the activity co-ordinator left a box of mobile phone chargers and headphones that posed a ligature risk, with a member of ward staff in a communal area, asking that she look after this whilst he collected some takeaway food that had been ordered by patients from the ward entrance. On his return, the box was unattended in the presence of patients with a high risk of ligature and suicide, with no member of ward staff present to keep patients who required level 2 and level 3 observations. This was not reported to the nurse in charge, and no incident report was completed. Evidence was that there were many new staff and that breaches of procedure were a regular occurrence. This left patients at risk. Evidence

	was heard that patients are still being left without the required observations since this death. 7. Oxevision imaging showed Elise entering her bedroom alone at approximately 18:10 hours and she remained in her room until she was found unresponsive at approximately 18:29. Elise's observation logs for 17:30-18:30 on 17 April were falsified recording that Elise was in the communal area with checks completed at 17:30 17:40 17:50 18:00 18:10 and 18:20 recorded that Elise was present in the communal area. Elise was required to be on constant eyesight observations whilst in her bedroom. 8. The mental health Trust were on notice that staff must have falsified the observations logs for Elise in 2021. Another inquest for a St. Aubyn's patient who died on 12 July 2022, also found that observation logs were falsified and contained errors. Trust staff falsification of records were not further investigated or monitored after Elise's death at St. Aubyn's Centre. 9. Elise's key nurse was working nights and was not having the required 1:1 with Elise and key documents were not completed for Elise's care. Inaccuracies and inconsistencies in record-keeping remains a concern. 10. Whilst this did not directly cause Elise's death, there were plenty of staff who responded quickly to the emergency when Elise was found unresponsive but there was a delay: a. bringing the grab bag to this emergency b. obtaining and attaching the defibrillator. c. In notifying the duty doctor who was not contacted for over 40 minutes. d. The expert witness was of the opinion once the defibrillator was attached, it was being switched on and off in the first few minutes. When looking at the machine analysis there appeared to be 3 analysis checks on the machine within the first few minutes when the machine is set to conduct analysis at set intervals which is inconsistent with this.
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 6 April 2026. 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: • Family • All Interested Persons I have also sent it to Care Quality Commission who may find it useful or of interest. 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	[redacted] **8 February 2026** **HM Area Coroner for Essex Sonia Hayes**