NHS
Mid and South Essex
NHS Foundation Trust

HM Area Coroner
Ms Sonia Hayes
Seax House
Victoria Road South
Chelmsford
Essex CM1 1QH

[redacted]

[redacted]

Date: 21 July 2026

Dear Ms Hayes

Regulation 28 Report to Prevent Future Deaths- Ms Abbigail Smith

I write further to your Regulation 28 Report to Prevent Future Deaths ('PFDR') dated 27 May 2026, relating to the Inquest of Ms Abbigail Smith ('Abbi').

We have considered your concerns and set out our formal response to each matter using your numbering as follows.

Matters of Concern

1. **There were not sufficient trained staff to conduct the enhanced observations required to monitor Abbi with her known risk of severe self-harm whilst she was awaiting assessment under the Mental Health Act and actively attempting to take her own life.**

Upon review of the relevant rotas, we can confirm that staffing on the night of 26.01.22 was adequate with 15 Registered Nurses and 9 Health care assistants and one registered Nurse that worked a twilight shift 1500-0300. The optimum staffing levels at that time for a night shift was 16 Registered Nurses and 9 Healthcare Assistants.

We acknowledge the concerns of HM Coroner that lack of staffing led to the provision of a security guard in order to support the Mental Health Team. We have not identified any evidence of a Trust-employed security staff being allocated to patients that night, as would usually be documented. In any event, we are not able to comment on staffing of the mental health team which would fall within the remit of Essex Partnership University Foundation Trust (EPUT).

2. **For a period of time Abbi was left under the observation of staff that were security personnel and were not appropriate or trained to undertake this work. Male security staff were informed that Abbi should use a commode due to her presenting risks and there were not sufficient trained female staff available. There had been a previous incident where actions taken to restrain Abbi by security personnel caused her trauma and there had been an allegation of assault, this was not considered in this admission.**

   I understand that the Court has been provided with an updated copy of the Trust's Policy for Enhanced Supervision and Engagement. This policy strengthens our assessment and guidance for patients requiring enhanced supervision as per the attached tool.

   Under the terms of the policy, where a patient meets the threshold for Enhanced Supervision, the patient's views should be considered when determining the appropriate member of staff to conduct the observation. Staff should also engage with the relevant family member/ carer/ key professional/ Lasting Power of Attorney and keep them informed about the care plan and the enhanced supervision which is in place.

   In Abbi's case, there should have been discussion about Abbi's previous history regarding restraint, and discussions should have taken place as to how enhanced supervision could have been put in place in a manner which was supportive to Abbi.

3. **Abbi at times had to be physically and chemically restrained due to the level of distress and harm to herself. During her admissions Abbi was able to access ligature material that she tied around her neck on multiple occasions over multiple days including her socks, cords from her clothing and pull cords in the bathroom. There were no appropriate care plan and risk assessments to mitigate a significant known risk.**

   I am aware that the Court has been provided with an updated copy of the Trust's Policy for Ligature and Self Harm Awareness.

   This policy requires the performance of ligature risk assessments and recognises the potential use of clothing items as a ligature. Where it is identified that clothing could present a ligature risk, this will be assessed on a case-by-case basis with regards to the need to balance the patient's dignity. Where a ligature item is not removed, the rationale for not removing the item and any mitigating actions should be documented and communicated with staff.

4. **Abbi was a complex mental health patient awaiting assessment under the Mental Health Act and was being cared for in a part of the hospital that was not suitable for a patient who was actively attempting to take her life.**

Our Policy for Ligature and Self Harm Awareness require environmental risk assessments to be performed in regard to clinical and non-clinical areas. These risk assessments are considered by staff before placing a potentially at-risk patient within the area.

5. **Staff left Abbi unsupervised during the admission to attend to other patients that permitted her to tie ligatures.**

Our Policy for Enhanced Supervision and Engagement, risk assesses patients at five different levels. As Abbi was risk assessed as Level 4 Enhanced Supervision, she should not have been left unsupervised due to the severity of her behaviours.

Enhanced Supervision is part of mandatory training for all staff who are involved with providing enhanced supervision to patients.

6. **No adjustments or plans were made for communication for Abbi as a patient with Autism and learning difficulty.**

For patients with Learning Disabilities, a Hospital Passport should be completed which includes questions such as '*How I communicate and how you communicate with me'* and any sensory issues which may impact communication.

For patients with Autism and or learning difficulties such as Abbi, the Trust uses the Autism Health Passport which has been created by the National Autistic Society. This includes questions such as '*How I would like you to communicate with me'* and '*How I communicate.'*

Our specialist Learning Disabilities ('LD') Team is trained to support and advise staff on patient communication needs; any sensory needs or sensitivities; pain recognition; interaction with medical history and any medication regimens; and to ensure reasonable adjustments are considered in line with the Equality Act 2010 and the Mental Capacity Act 2005. For example, this may be facilitating a patient being placed in a quiet area away from populated waiting rooms and information being given that is free of jargon and medical terminology.

In addition to the above, our LD Team and Autism Lead are available to support clinical teams with devising individual care plans and responding to learning difficulty support queries. Our clinical teams work collaboratively with the LD team ensuring as far as possible that appropriate adjustments are made for patients, providing the most therapeutic environment for their care.

Our teams have reflected deeply on Abbi's experience as evidence by the changes and improvements detailed above. We hope that these actions will assure the Court we have made changes to our practice within the Trust, and we are committed to ongoing learning from this case.

If I can assist further with these matters, please do not hesitate to contact me.

Yours sincerely,

Chief Executive
Mid and South Essex NHS Foundation Trust

Enc: Appendix 1 Safe and Supportive non-clinical supervision of patients tool

NHS
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Affix Patient ID Label wholly inside this region

Family Name:

Given Name

Hospital No: Gender:

NHS No: DOB: / /

Affix Patient ID Label wholly inside this region

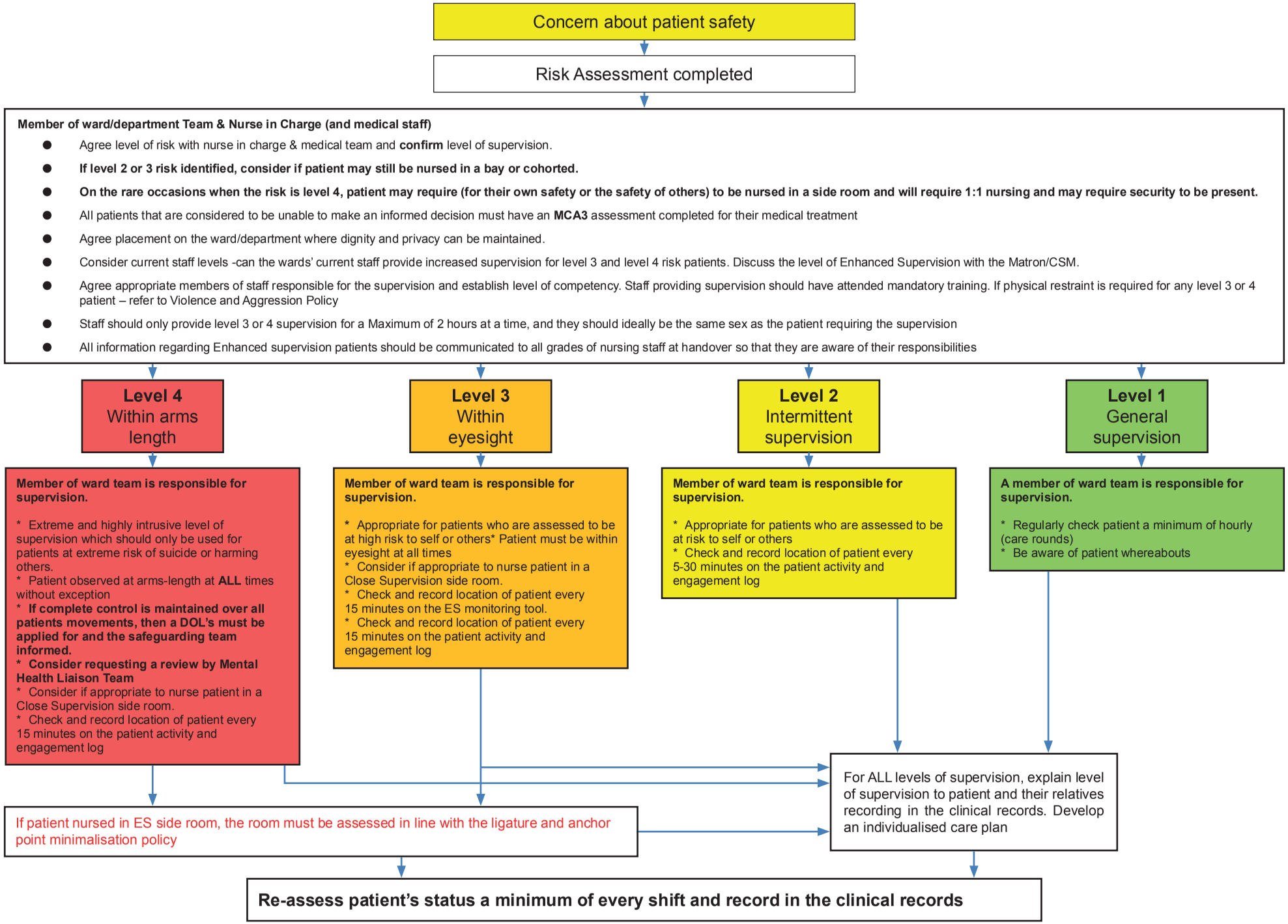
NON-CLINICAL SUPERVISION OF PATIENTS

Version: 1
Order Ref: MSESAFESUPP
Approved: 14/11/2022
Review By: 14/11/2024
File Under: Health Record\Clinical Record

Form ID: GNH346

Do not write on or obscure the barcode

SAFE AND SUPPORTIVE NON-CLINICAL SUPERVISION OF PATIENTS


Concern about patient safety
Risk Assessment completed
Member of ward/department Team & Nurse in Charge (and medical staff)
Agree level of risk with nurse in charge & medical team and confirm level of supervision.
If level 2 or 3 risk identified, consider if patient may still be nursed in a bay or cohorted.
On the rare occasions when the risk is level 4, patient may require (for their own safety or the safety of others) to be nursed in a side room and will require 1:1 nursing and may require security to be present.
All patients that are considered to be unable to make an informed decision must have an MCA3 assessment completed for their medical treatment
Agree placement on the ward/department where dignity and privacy can be maintained.
Consider current staff levels -can the wards' current staff provide increased supervision for level 3 and level 4 risk patients. Discuss the level of Enhanced Supervision with the Matron/CSM.
Agree appropriate members of staff responsible for the supervision and establish level of competency. Staff providing supervision should have attended mandatory training. If physical restraint is required for any level 3 or 4 patient – refer to Violence and Aggression Policy
Staff should only provide level 3 or 4 supervision for a Maximum of 2 hours at a time, and they should ideally be the same sex as the patient requiring the supervision
All information regarding Enhanced supervision patients should be communicated to all grades of nursing staff at handover so that they are aware of their responsibilities
Level 4 Within arms length
Level 3 Within eyesight
Level 2 Intermittent supervision
Level 1 General supervision
Member of ward team is responsible for supervision.
* Extreme and highly intrusive level of supervision which should only be used for patients at extreme risk of suicide or harming others.
* Patient observed at arms-length at ALL times without exception
* If complete control is maintained over all patients movements, then a DOL's must be applied for and the safeguarding team informed.
* Consider requesting a review by Mental Health Liaison Team
* Consider if appropriate to nurse patient in a Close Supervision side room.
* Check and record location of patient every 15 minutes on the patient activity and engagement log
Member of ward team is responsible for supervision.
* Appropriate for patients who are assessed to be at high risk to self or others* Patient must be within eyesight at all times
* Consider if appropriate to nurse patient in a Close Supervision side room.
* Check and record location of patient every 15 minutes on the ES monitoring tool.
* Check and record location of patient every 15 minutes on the patient activity and engagement log
Member of ward team is responsible for supervision.
* Appropriate for patients who are assessed to be at risk to self or others
* Check and record location of patient every 5-30 minutes on the patient activity and engagement log
A member of ward team is responsible for supervision.
* Regularly check patient a minimum of hourly (care rounds)
* Be aware of patient whereabouts
For ALL levels of supervision, explain level of supervision to patient and their relatives recording in the clinical records. Develop an individualised care plan
If patient nursed in ES side room, the room must be assessed in line with the ligature and anchor point minimalisation policy
Re-assess patient's status a minimum of every shift and record in the clinical records

Mid and South Essex NHS Foundation Trust

Enhanced Supervision Assessment

Enhanced Supervision Assessment Tool

Patient ID Label

Assess patient and tick the appropriate box in the table below

Observed by assessing nurse

- ☐ Violent behaviour
- ☐ Possession of a weapon
- ☐ Significant self-harming behaviour
- ☐ Severe risk of danger to self or others
- ☐ Environmentally destructive

Reported by patient/family/carer during assessment

- ☐ Definite danger to life, self or others
- ☐ Severe risk of danger to self or others

YES → **Red Level 4**

Level 4 Within arm's length

Extreme and highly intrusive level of supervision which should only be used for patients at extreme risk of suicide, harming self or harming others

Patient observed within arms length at ALL times without exception

If complete control is maintained over all patients' movements then a DOLS must be applied for and the safeguarding team informed where patient assessed as lacking capacity

Consider if appropriate to nurse patient in a ES side room. Consider requesting a RMN to provide ES but only with Matron/CSM agreement

Suggested method of supervision

Ward Staff responsible.

If current staffing levels do not allow ward staff to provide ES Additional staff may be required. Refer to Flow Chart 2 – Decision Tree

If the patient has, or is exhibiting violence or aggressive tendencies and there is a need for security to be present on the ward, these staff members **MUST NOT** be utilised to provide enhanced supervision in the ward areas

Consider requesting a review by the Mental Health Liaison Team

NO

Observed by assessing nurse

- ☐ High risk of harm to others
- ☐ High risk of further self-harm
- ☐ Probable risk of danger to self or others
  High level or agitation/anxiety
- ☐ Patient physically restrained in A&R department
- ☐ Extreme agitation/restlessness
- ☐ Physically/verbally aggressive
- ☐ Confused/unable to co-operate

Reported by patient/family/carer during assessment

- ☐ High risk of harm to others
- ☐ High risk of further self-harm
- ☐ Probable risk of danger to self or others
- ☐ High level or agitation/anxiety
- ☐ Patient required to have been physically restrained in A&E department/AMU 1 or 2 in past 48 hours
- ☐ Attempt at self-harm / threat of self-harm
- ☐ Threat of harm to others

YES → **Orange Level 3**

Level 3 Within eyesight

Member of ward team is responsible for supervision.

Appropriate for patients who are assessed at high risk to self or others

Patient must be within eyesight at all times

Check and record location of patient every 15 minutes on the ES Patient Monitoring Tool

Suggested method of supervision

Ward Staff responsible.

Consider nursing patients within a cohort if there is more than one patient requiring this level of supervision

If current staffing levels do not allow ward staff to provide ES. Additional staff may be required. Refer to Flow Chart 2 – Decision Tree

NO

Observed by assessing nurse

- ☐ Agitated restless or intrusive behaviour
- ☐ Bizarre, disordered behaviour
- ☐ Confused; withdrawn, uncommunicative
- ☐ Ambivalence about treatment
- ☐ Marked distress
- ☐ Moderate behavioural disturbance
- ☐ Found pacing or wandering on 2 or more occasions in the past 24 hours
- ☐ Disruptive
- ☐ Confused not cooperative and is bedbound
- ☐ Triggers easily de-escalated

Reported by patient/family/carer during assessment

- ☐ Suicidal ideation
- ☐ Presence of psychotic symptoms: Hallucinations, delusions, paranoid ideas
- ☐ Thought disorder, bizarre, agitated behaviour
- ☐ Presence of mood disturbance – severe symptoms of depression and or anxiety
- ☐ Elated or irritable mood
- ☐ Might the patient abscond – placing them at significant risk of harm
- ☐ Reported pacing or wandering on 2 occasions in the past 24 hours
- ☐ Significant psychiatric history
- ☐ Moderate risk of further self-harm
- ☐ Inappropriate behaviour or history
- ☐ Possible danger to others

YES → **Yellow Level 2**

Level 2 Intermittent level of supervision

This indicates that a patient's location is being checked at intermittent intervals within a given timescale

This level is appropriate when patients are potentially but not immediately at risk
Consideration should be given to the placement of the patient within the ward

Suggested method of supervision

Ward Staff responsible.
Check and record location of patient every 5-30 minutes
Encourage open visiting
Consider nursing patients within a cohort if there is more than one patient requiring this level of supervision

NO

Observed by assessing nurse

- ☐ Moderate distress
- ☐ No agitation / restlessness
- ☐ Irritable without aggression
- ☐ Gives coherent history
- ☐ Co-operative
- ☐ Communicative
- ☐ Compliant with instructions
- ☐ No danger to self or others
- ☐ No behavioural disturbance

Reported by patient/family/carer during assessment

- ☐ Inappropriate behaviour or history
- ☐ Possible danger to others
- ☐ Known patient with chronic unexplained somatic symptoms
- ☐ Requests for medication
- ☐ Minor adverse effect of medication
- ☐ Financial/social/accommodation/or relationship problems

YES → **Green Level 1**

Level 1 General Supervision

This implies the informal supervision of all patients within the established staffing levels of that clinical area. This means patients do not need to be kept in sight constantly and may leave the clinical setting with permission and staff should be aware of the whereabouts of the patient at all times. This information should form part of the handover.

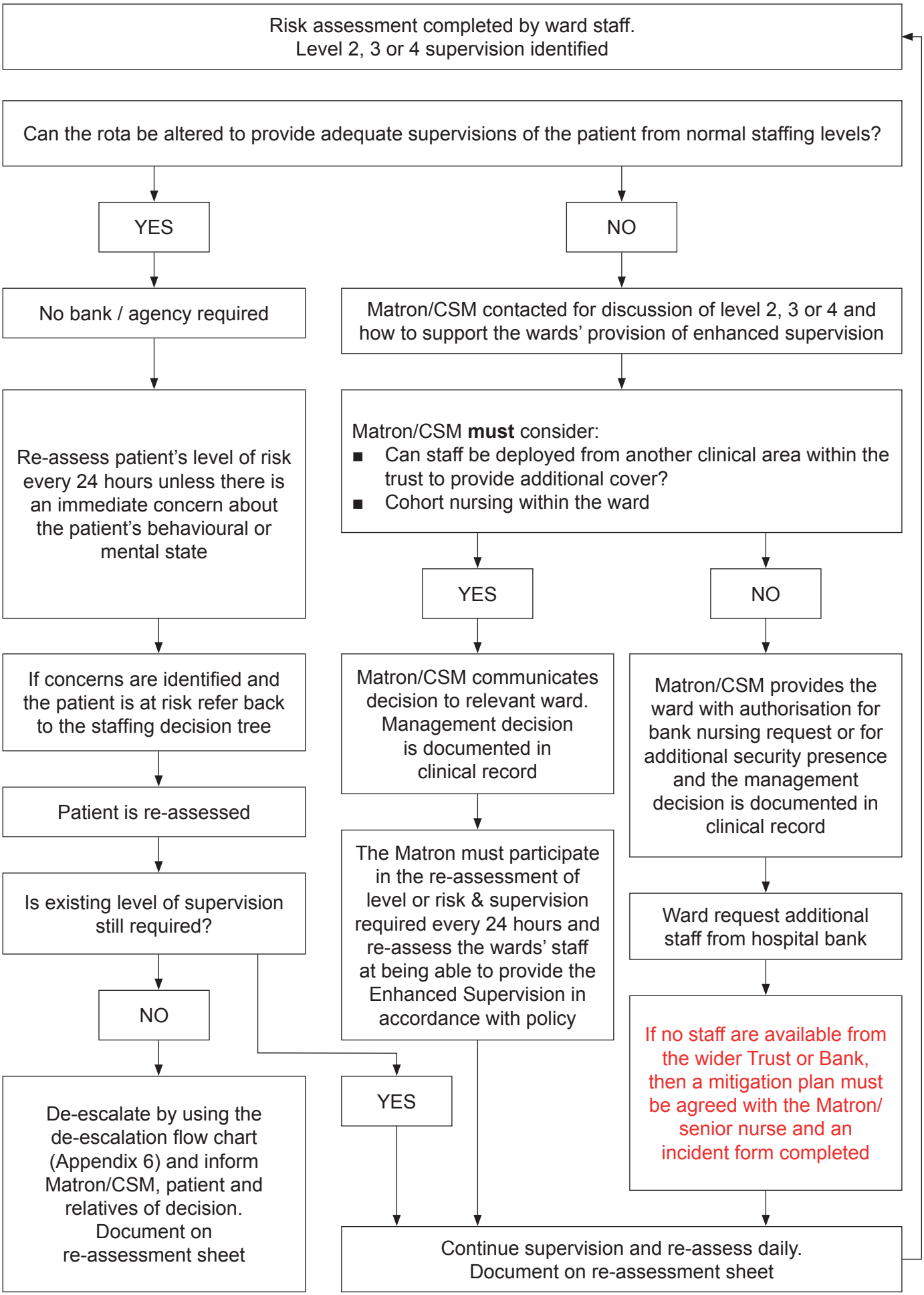
Suggested method of supervision

Ward Staff
Care rounds

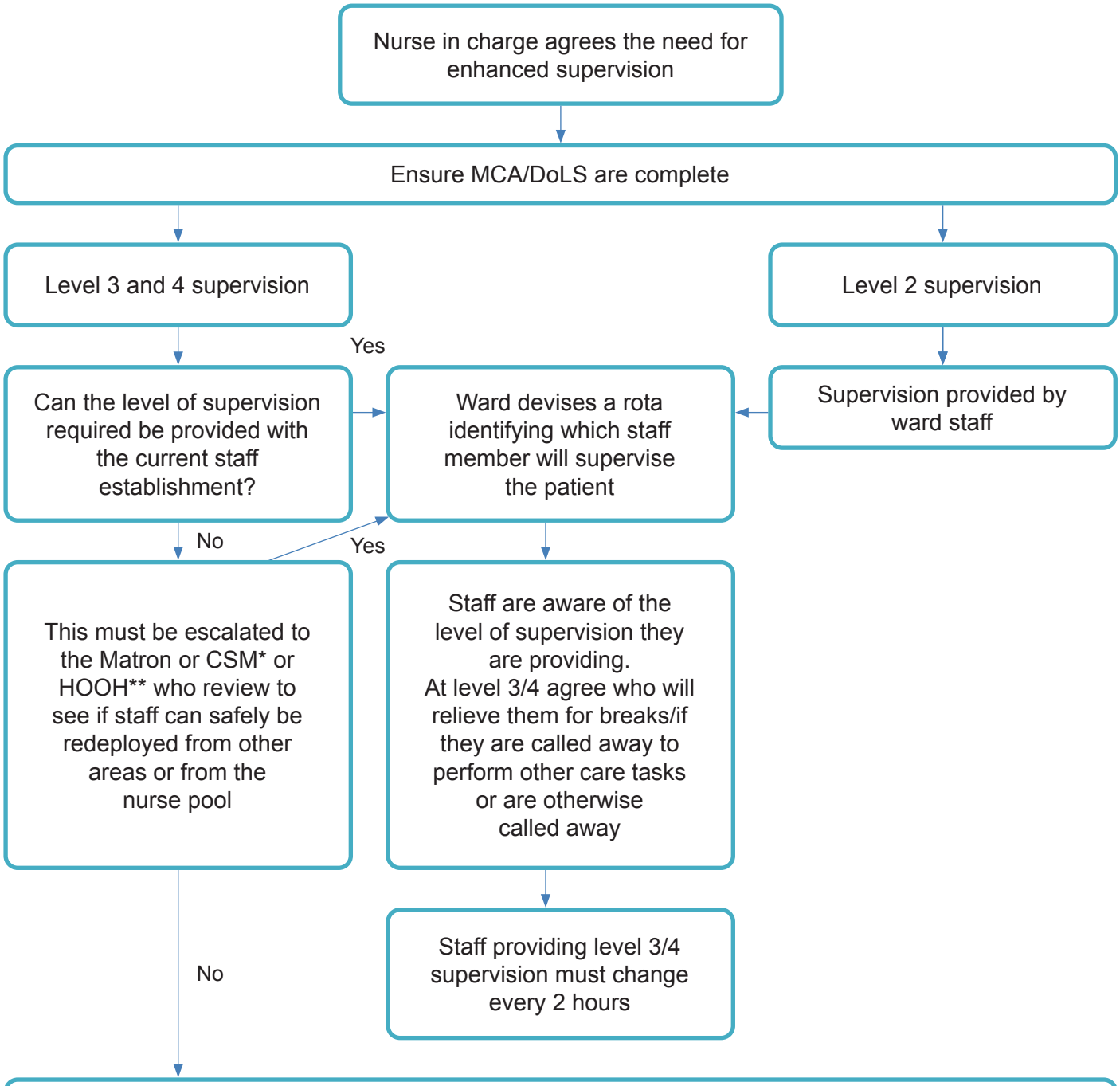
Name of assessing nurse:					Date:		
Level of ES identified:	☐ Level 1	☐ Level 2	☐ Level 3	☐ Level 4	Additional staff required:	☐ Yes	☐ No

Ward Manager / Matron / Clinical Site Manager MUST complete the ES Authorisation form on Teams

Decision Tree for the Safe Management of an At-Risk Patient



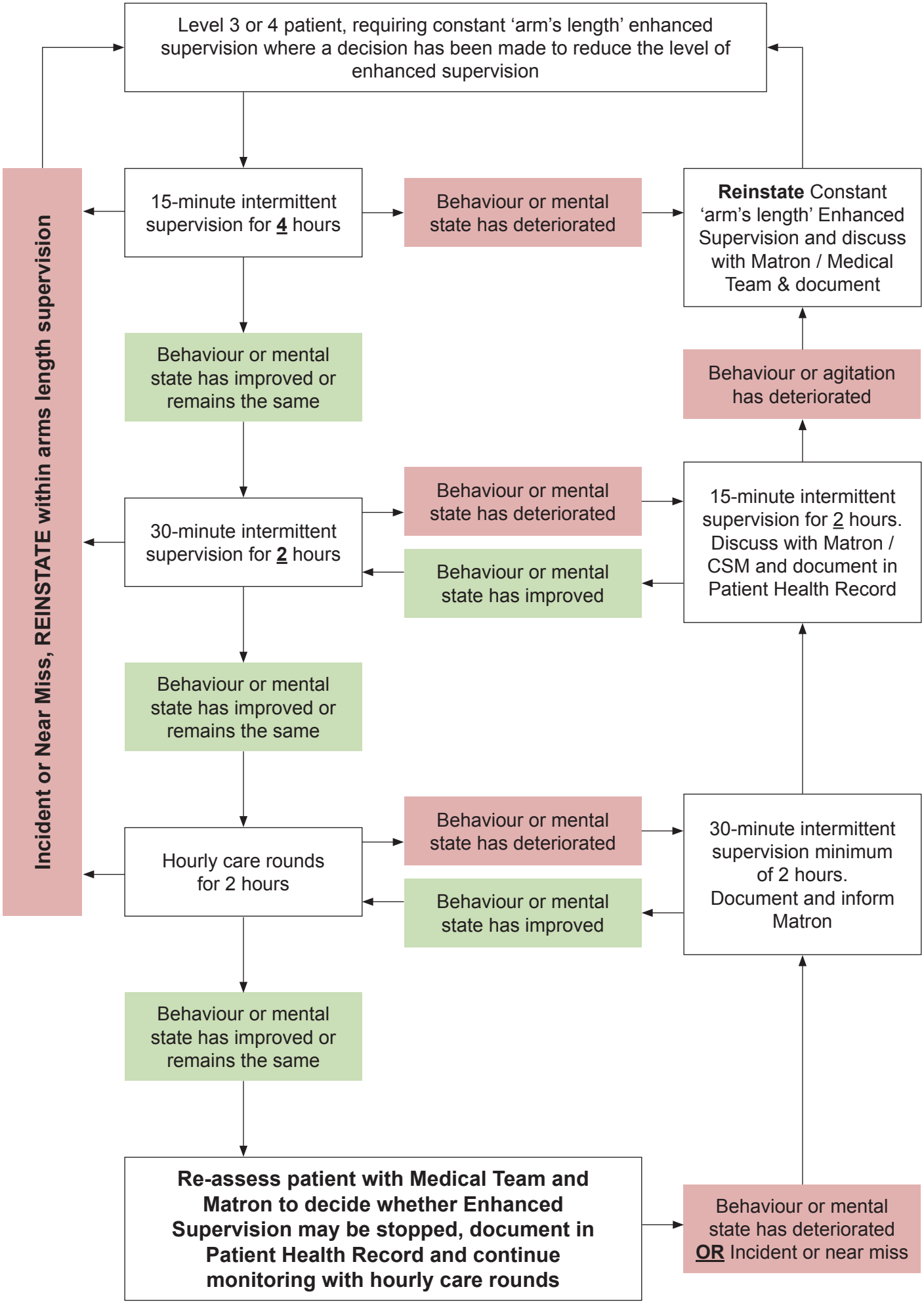
Staffing Decision Tree



*CSM – Clinical Site Manager
**HOOH – Hospital Out Of Hours

Patient level of supervision must be assessed a minimum of every 24hrs or more frequently if the patient's condition dictates.				
Date				
Time				
Document deviation from admission Enhanced Supervision assessment i.e., what has changed?				
Level of supervision				
Supervision frequency				
Level of supervision increased				
Level of supervision decreased				
Signature				
Designation				

Flow Chart for De-escalation of Constant Enhanced Supervision



STAFF GUIDE WHEN PROVIDING ENHANCED SUPERVISION FOR PATIENTS

- **Being an inpatient can be one of the loneliest places you'll ever be and explains why patient engagement is so important.**
- **Conversation is the most powerful form of engagement and below are some ideas of topics of conversation plus some other activities to promote patient engagement.**
- **Ensure patient activities and engagement are documented including the outcome the activity or engagement has had on the patient's mood and / or behaviour.**
- **Always use the patients 'This is Me' document or Hospital Passport if available**
- **Please ensure your patient is not in any pain. (Consider Abbey pain scale)**

Engagement can include the following

- Encourage patients to be independent with their activities of daily living including toileting, washing and dressing, nutrition and hydration
- Engage in activities that elicit sensory-motor feedback and assist with orientation such as reading a news article, providing a clock and calendar
- Mechanisms for Calming – going to a space that is less noisy and busy, or with reduced lighting, and:
- VERA (Validation, Emotion, Reassure, Activity) – acknowledge their reality (even if different to ours) and acknowledge their feeling and empathise. (This is me has a section about what worries the person and what makes them feel better)
- Mechanisms for Soothing – music, sensory activities, weighted blanket.
- Mechanisms for distracting attention – music, popping bubble wrap, colouring-in, games
- Engage the patient in a personal care activity - sensory, nutritional, self-awareness.
- Utilise the therapy staffs' skills and knowledge to help encourage physical activity including walking around the ward, garden or around the grounds
- Engage the patient in a self-care task washing, dressing, make-up, hair, shaving
- Engage the patient in a food/drink-based task
- Engage the patient in a sensory activity such as self-massage, relaxation, soft music.
- Social Interaction — (Respect patient's right for silence!). If patient wishes to talk, talk and introduce general conversation topics. Reminisce over their previous or current hobbies or interests.

Documentation examples

- Observed behaviour – getting up to leave, calling out, aggression, hallucination
- Observed thoughts – belief, opinion, paranoid, irrational, perception
- Observed Mood – happy, sad, anxious, frustrated, angry, content, calm
- Observed Physical – pain, withdrawn, hitting out, physiological changes (sweating / panting), urine retention, constipation
- Environmental – dark, noisy, bay, side room, cold, hot, day, night, bed or ward move
- What is the patient communicating? – desire to leave, pain, boredom, toileting, loneliness, fear, hunger, thirst
- Potential triggers – family leaving, pain, personal care, toileting
- Emotional interventions – reassurance, meaningful activities, talk about family, reminiscence
- Physical Interventions – taken to the toilet, analgesia, given food/drink, taken for a walk, changed clothes
- Environmental Interventions – trigger removed, allocated to side room, break out area found, take out to garden

PATIENT ENGAGEMENT AND ACTIVITY LOG

- Use the staff guide on engagement when providing enhanced supervision to your patient
- Documentation should be a minimum of hourly
- Utilise ward resources such as twiddle muffs, games, colouring books etc.
- Familiarise yourself with the patients This is Me document (if available)
- Engage with family / carers / friends
- Try to identify what triggers a patient's particular mood / behaviour and what interventions may help to resolve them

- Make sure you document and share at handover the interventions that have been effective. Handover must be to the RN.
- Ensure you are aware of the level of Supervision you are being asked to provide and, for supervised bays and levels 3 (within eyesight) and 4 (within arm's length) supervision, the mitigation in place should you need to leave the area for any reason.
- Monitor and report any changes in behaviour or condition to the Nurse in Charge

DATE	TIME	PATIENT ACTIVITY	NURSING INTERVENTION AND OUTCOME	PRINT NAME & SIGNATURE

DATE	TIME	PATIENT ACTIVITY	NURSING INTERVENTION AND OUTCOME	PRINT NAME & SIGNATURE