CORONER'S OFFICE
DISTRICT OF HERTFORDSHIRE

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MR EDWARD G. THOMAS Senior Coroner
MR GRAHAM DANBURY, Dr FRANCES CRANFIELD, ALISON GRIEF, EDWARD SOLOMONS
Assistant Coroners

9 April 2014

Sent by email to [redacted]

The Compliance Manager
Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Your Ref: to be advised
Our Ref: 01254-2012

Dear Sir,

Re: Ozan Cem ATASOY, deceased

I am writing to you under the provisions of Schedule 5 (paragraph 7) of the Coroners & Justice Act 2009 which came into force in July 2013. This re-enacted the provisions of the old Rule 43 of the Coroners Rules 1984. Attached to this letter is information concerning the new rules and regulations from which you will see requires a written response. Copies of this letter and the response received from you will be forwarded to the other interested persons identified at the inquest in accordance with the list attached. I am also sending a copy of this letter to the Department of Health for their general information.

On the 28th February 2014, I concluded an inquest that I had conducted over four days with a jury into the tragic death of Ozan Cem Atasoy (whom I will hereafter refer to as Ozan). Please find attached a copy of the Record of Inquest, which includes the jury's findings. Ozan suffered from treatment resistant schizophrenia following diagnosis in 1999. Ozan was predominantly under the care of [redacted] with whom the family indicated they had a good and trusting relationship. Ozan had a number of in-patient admissions which when in Hertfordshire, [redacted] would remain his responsible clinician. [redacted] also continued as his community clinician supporting him, with a care coordinator, in trying to maintain stability while resident in his flat in Hatfield. Ozan had been prescribed high doses of clozapine, but there was a deterioration in his mental health, particularly recently whilst taking the legal high "Natural Waves". His family reported that Ozan's reason for taking "Natural Waves" was that they were legal and also helped him deal with the auditory command hallucinations which commanded him to take risks that severely jeopardised his safety.

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In April 2012, Ozan's condition deteriorated to the extent that he was admitted voluntary to the Mymms Ward at the Queen Elizabeth II Hospital, Welwyn Garden City, and then after absconding several times, detained under Section 3, overwhelmingly for his own safety according to [redacted] After further absconding he was placed in the local Psychiatric Intensive Care Unit for approximately seven days. (please see attached chronology that was agreed to by the interested persons) You will note the number of times that Ozan absconded, believed always from the smoking area and often when escorted on breaks by nursing staff. On the last time he absconded on the 6th May 2012, it appeared he "tail gated" an informal patient who was allowed to leave without being escorted. The doors on the floor to the lift had been opened when a release button in the nurses' room had been activated. The geography of the unit meant that the health care assistant did not have a full view of the door when she pressed the button to release those doors.

Ozan's body was found some 13 days later and from toxicology analysis it appears he died within 24 to 68 hours form the time that he last took his Clozapine at breakfast time on 6th May.

Mymms Ward is situated at Queen Elizabeth II Hospital, Welwyn Garden City, which is also a general hospital. Mymms Ward is one of three wards in the psychiatric unit and is on the second floor accessed by lifts. The building was erected in the 1960's and was originally run by the general hospital. Until 2009 there was a smoking room which patients could use. New regulations concerning smoking in enclosed premises and the need to access fresh air meant the garden was the only place where patients could smoke whilst in the confines of the unit. A 1.74 metre fence was erected and Ozan was able to vault that height in order to leave the unit. Mymms Ward and the other two wards in the psychiatric unit are designated an open wards, and the jury and I were informed that there are no regulations in respect of the height of fencing that provided an enclosed area for fresh air and smoking. After Ozan's death in 2012 the height of the fence was increased to 3 metres, which I was told was the height required for low secure services, and even then there has been one incident of absconding by another patient. The Trust operating the unit is most reluctant to "cage" the area, no doubt to avoid patients feeling they are in a "prison" environment. Incidentally, the unit manager informed me they never have children as in-patients in this unit.

The Acute Service Manager gave evidence that they needed to have obtained the permission of the Acute Trust at the general hospital and planning permission to increase the height of the fence. Despite contact with the local authority on two occasions for advice after Ozan had died, there had been no response from that authority but they raised the fence in any event. The Trust has now confirmed that there were plans for all units in Hertfordshire similar to the unit at Welwyn Garden City to be closed. A purpose built unit is in the course of construction at the old Harperbury Hospital site which will shortly be opened.

There were other issues raised at the inquest, which although could not be said to have contributed to Ozan's death, were nonetheless matters I felt would be helpful to draw your attention to in your role as protecting and monitoring services at mental health in-patient units. I was told that there are many psychiatric units in acute trusts built in a similar way and therefore some of the changes being made might be useful for units throughout the country.

The primary structural changes apart from moving site are:

- The raising of the fence from 1.74 metres to about 3 metres.
- The security of the door leading into the garden can only be opened by staff by swipe card, given that the previous door was easy to open by pushing hard.

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- The release buttons for doors to the unit should be operated by somebody who was able to have full and uninterrupted access to the sight of the doors so they could see who was going in and out and whether somebody would be "tail gating".
- The CCTV system now records who was at external doors before opening systems are operated remotely.

The jury's findings included a failure to communicate concerns about the height of the fence to senior management and a general lack of communication with management.

Observations
At the time of Ozan's death his observations had been changed from 15 minutes to every 5 minutes. After the attempted tail-gaiting incident of the 3rd May 2012, the jury felt that the observations should have been increased to continuous in accordance with the treatment and care plan. Evidence was given that although staff had been given in-house training the care assistant could not recollect having received any training. Training is now provided by an external trainer which staff have found helpful.

The observation policy has changed so that there are no "5 minute observations".

The jury concluded failure to change the observations to continuous after the attempted tail-gaiting incident on the 3rd May significantly contributed to Ozan's death. A 9 to 2 majority concluded that any return to PICU was unnecessary as evidence from PICU was that they would only be able to have Ozan for no more than two months and many of the patients were violent and sometimes required 3 to 1 containment. Ozan never posed any management problems whilst on the ward beyond staff being extremely alert to the possibility of absconding.

Named Nurse
Ozan was allocated a named nurse. He had a care coordinator in the community and the Serious Incident Report indicated the named nurse was unclear that they were the named nurse or their role. I understand further training has been on the role of a named nurse since the incident

Occupational Therapy
There was discussion at the inquest on the provision of occupational therapy and the note indicated that there was occupational therapy although not at weekends, as well as referral to psychology and to substance misuse specialist support. The treatment plan was for Ozan's mental health to be stabilised once the effect of "Natural Waves" on his mental health had diminished. Ozan presented as quiet and was difficult to communicate with, no doubt due to the impact of his voices. The family felt there was a lack of engagement with Ozan on the ward.

Staffing Levels
Mymms Ward was able to accommodate twenty patients. At the time of the incident there were fifteen on the ward with two on leave. Nine of those patients were detained, eight under Section 3 and one under Section 37/41. Information communicated during handover was good; it was recorded in bold type that Ozan was "very high risk of absconding. No breaks off the ward at present". Each patient had details about their status, leave entitlement and risk, which was also communicated on a whiteboard in the office. The normal staffing ratio for this number of patients was two nurses and three health care assistants. The staffing ratio at PICU was five staff to ten patients.

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[redacted] [redacted] gave evidence of the changes to those likely to be admitted to a hospital over the years that he had been in practice and it is clear that many of those who might have been admitted in the past, usually informally, are now cared for in the community by the crisis teams and with the early intervention psychosis team. This therefore means that patients who are admitted are likely to be more complex regarding risks and the handover notes indicated that many of those patients certainly had risks relating to self harm. [redacted] [redacted] gave evidence that many of the experienced staff with whom he had worked over a number of years had moved to working in community teams, which he felt had affected the calibre of staff working on the ward and the way the staff engaged with patients.

I was given copies of the following documents:

- "How to Ensure the Right People, with the Right Skills, are in the Right Place at the Right Time
- A Guide to Nursing, Midwifery and Care Staffing Capacity and Capability
- Forward from the Chief Nursing Officer for England, Nurse Cummings".

I noted on page 25, case study number three from the Hertfordshire Partnership University Trust concerning the updating of "Managed Exit and Entry Policy", focusing on correct and safe staffing on acute admission wards when informal patients are entitled to leave the unit and formal patients detained under the Mental Health Act.

I have drawn your attention to the number of issues raised at the inquest and to the changes Hertfordshire Partnership University Trust have put in place in order for them to try and learn the lessons from the tragic death of Ozan. I would be grateful if you could confirm that you will be disseminating the information contained in this report and would welcome your response on the general issues that have been raised on the matters outlined, particularly in relation to inspections of hospitals built in a similar way to Queen Elizabeth II Hospital, Welwyn Garden City, which I understood from the Trust's legal representatives there were many.

The schedule requires a response from you within 56 days of receipt which I calculate is the Wednesday 24th June 2014. Please let me know if there are difficulties in complying with this timescale or whether there is anything you wish to discuss. I am willing to extend the deadline if there is good reason to do so.

Many thanks for your anticipated assistance in helping to provide safe and therapeutic environments for all in-patients.

Yours sincerely

Edward G Thomas
Senior Coroner