Re : ADAM JAMES WITHERS DECEASED

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Surrey and Borders Partnership NHS Foundation Trust (in relation to paragraph 5 A and B below),** **2. The Secretary of State for Health (in relation to paragraph 5 B and C below), and** **3. NHS England (in relation to paragraph 5 C below).**
1	**CORONER** I am Alison Hewitt, Assistant Coroner for the coroner area of Surrey.
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** I commenced an investigation into the death of Adam James Withers aged 20 years. The investigation concluded at the end of the inquest on 22nd January 2016. The jury's conclusion as to the death was that : "Whilst suffering an acute psychotic illness, Adam Withers climbed to the top of a 130 foot chimney and fell from it unintentionally. Adam Withers' death was caused or more than minimally contributed to by : (1) A failure by the Surrey and Borders Partnership NHS Foundation Trust to take effective steps to address the known risk of detained patients absconding from the Elgar Ward courtyard via its flat roof. (2) A failure by the Surrey and Borders Partnership NHS Foundation Trust on 9th May 2014 to reassess Adam's risk levels after his comment in relation to climbing the ladder on the chimney. (3) A failure by the Surrey and Borders Partnership NHS Foundation Trust on 9th May 2014 to take effective steps to prevent Adam from absconding from Elgar Ward pending

	reassessment of his risk levels after his comment in relation to climbing the ladder on the chimney. (4) A failure by Epsom and St Helier University Hospitals NHS Trust to take effective steps to prevent access to the ladder on the chimney. (5) In view of the healthcare requirements for the patients detained in the Langley Unit, there was a systemic failure by both Surrey and Borders Partnership NHS Foundation Trust and Epsom and St Helier University Hospitals NHS Trust to effectively communicate changes to the environment and take remedial action to address identified risks." At the conclusion of the inquest the Interested Persons were given time to make, and respond to, written submissions concerning my duty to make a report to prevent future deaths. I have received written submissions from all the Interested Persons save for the Health and Safety Executive, the last being received on the 5th February 2016.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of Adam Withers' death are set out in the jury's full findings of fact which were as follows : "Adam Withers was admitted to the Elgar Ward of the Epsom General Hospital as a voluntary patient on 14th April 2014 suffering from acute psychotic illness. Elgar Ward had a documented history between 2012 and 2014 of numerous patients absconding by climbing from its courtyard on to its flat roof and on 22nd April 2014 Adam Withers climbed from the courtyard on to its flat roof after being detained under section 3 of the Mental Health Act. As a result, Adam Withers was transferred to the Psychiatric Intensive Care Unit where on 23rd April 2014 he was further detained under section 2 of the Mental Health Act. On 2nd May 2014 there was a ladder attached to the full height of a 130 foot high chimney within the grounds of the Epsom General Hospital which was partly visible from the courtyard and bedrooms off the female corridor of Elgar Ward. This was for a maintenance inspection for the expected duration of one day and to be taken down on the same day. During the inspection, further remedial work was identified and at this point it was agreed that the ladder would be left in place until quotations had been received and the work carried out. On 5th May 2014 Adam Withers was transferred back to Elgar Ward from the Psychiatric Intensive Care Unit but his medical records do not indicate his risk of absconding being reviewed. On the morning of 9th May 2014 Adam Withers was placed on a 15 minute observation regime because of the risk of absconding. It was also observed but not logged that he was in an agitated state. During the afternoon, prior to 3.00pm, Adam was in the courtyard of Elgar Ward. In conversation with a member of staff he stated that he could see a ladder attached to the

	chimney and that he felt it was a message from God who wanted him to climb it. The member of staff subsequently passed this information to a member of nursing staff on the Elgar Ward. However, this was not effectively communicated in full to all staff on duty and neither was a further assessment taken as to Adam Withers' risk of absconsion and the need for increased supervision. Shortly after 6.00pm, Adam Withers was in the courtyard of Elgar Ward. Despite the risk assessment Item 35 of the RAI Form stating patients should be supervised whilst in the courtyard, there were no members of staff present. He absconded by climbing, via the conservatory, on to Elgar Ward's flat roof with ease and speed. A member of staff entered the courtyard when Adam Withers was on the roof of the conservatory and raised the alarm. From the flat roof of Elgar Ward, Adam Withers made his way without effective restriction to the base of the chimney where he overcame the security measures that had been put in place at the base of the ladder. Adam Withers climbed the ladder to the top of the chimney and fell to the ground and suffered fatal injuries as a result."
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern, some of which have now been addressed. However, in my opinion there is a risk that future deaths will occur unless action is taken in respect of the matters which have not yet been addressed or sufficiently addressed. In the circumstances it is my statutory duty to report to you. **A. To the Surrey and Borders Partnership NHS Foundation Trust** The **MATTERS OF CONCERN** are as follows : (1) It was apparent from the evidence that periodic observations of psychiatric patients are conducted not only to check that each is present, but also in order to observe and assess their current state of mind and presentation, by means of a meaningful interaction, if possible. The importance of nursing staff (Registered Nurses and Health Care Assistants) making a sufficient written record of these observations was acknowledged. Regular notes of a patient's condition are important for the purposes of diagnosis and they provide the information which is needed for a reliable assessment of the patient's progress and current level of risk of harm or death. It was accepted in evidence that this is especially so in relation to any patient whose condition fluctuates. It was clear from the evidence that the nursing staff involved in Adam Withers' care failed to record sufficiently his presentation and their interactions with him. For example, on the day of his death Adam Withers was subject to four observations per hour but no entries were made on his RIO notes or elsewhere about his state of mind or presentation at these observation points and no record was made about the conversation a nurse conducted with him that afternoon. Some of the nursing staff who gave evidence appeared to have little understanding of the need to make such written records and/or their importance.

If permitted to continue, the insufficient recording of observations and events could have an adverse impact on the assessment, treatment and care of current and future patients and upon the protection of their lives.

(2) It was clear from the evidence that any note made in a patient's record should be made contemporaneously or, if made later, should be timed, dated and labelled as retrospective. This is necessary to ensure that all notes are accurate and reliable.

The evidence at the inquest revealed that at least one member of nursing staff made entries on Adam Withers' manuscript observation record after he had died, without marking the entries as retrospective. When giving evidence, the member of staff in question did not appear to understand that he ought not to have done so.

If permitted to continue, this practice could result in current and future patients' notes containing inaccurate and unreliable, and potentially misleading, information and this could have an adverse impact on their assessment, treatment and care and upon the protection of their lives.

B. To : The Surrey and Borders Partnership NHS Foundation Trust, and

To : The Secretary of State for Health

The **MATTER OF CONCERN** is as follows :

(1) At the inquest an issue arose as to when the manuscript observation record for Adam Withers for the 9th May 2014 was completed and I asked to see the original document. I was provided with a witness statement from the Trust's Medical Records Manager indicating that, after Adam Withers' death, the original record had been scanned in to his electronic records and then destroyed. The Trust considers that this is permitted by the NHS Code of Practice on Record Management. It is not clear to me whether that is a correct analysis of the Code or not. No clear guidance appears to exist.

Whilst I understand that paper records may now routinely be scanned in to a patient's electronic record and then destroyed, my concern relates to that taking place after a patient has died and it is apparent that the death must be reported to the police and/or coroner. The destruction of any original document which is still in existence at the time of death could undermine the efficacy of the police investigation and/or the coroner's investigation. In turn, this could adversely affect the coroner's ability to establish the facts of how the deceased person came by his death and to report concerns for the prevention of future deaths.

	C. To : The Secretary of State for Health **To : NHS England** The **MATTER OF CONCERN** is as follows : (1) At the inquest the number of nursing staff (Registered Nurses and Health Care Assistants) on duty on Elgar Ward was considered. It was apparent from the evidence that the nursing staff levels could result in patients on the ward being insufficiently supervised at meal times and staff stated in evidence that they did not always have time to read patients' notes as they should. Further, Elgar Ward is an acute psychiatric ward with both detained and voluntary patients. It is foreseeable that reactive and unplanned interventions will be required at times and that the level of observation needed by each patient will fluctuate. The staffing levels on Elgar Ward were deemed sufficient for only a fixed number of patients to be subject to increased observation levels, and only one patient to be under constant observation, at any one time. I was informed that if more patients required increased or constant observation, additional staff would be needed but may not be readily available. I have been told by the Trust that no nationally prescribed safe staffing levels are in place for an acute psychiatric ward (whether based on patient to staff ratios or otherwise) and that the Trust considers its staffing levels to be in accordance with such guidelines as do exist. The Mental Health Taskforce's recently published report entitled "The Five Year Forward View For Mental Health" does not appear to address this issue. It does seem that the absence of prescribed safe nursing staff levels for acute psychiatric wards could leave such wards unable to provide, throughout each shift, the level of patient supervision, observation and intervention needed. This could adversely affect the staff's ability to protect their patients' lives.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths by addressing the concerns set out above and I believe you 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 12th April 2016. 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 to the others listed below who may find it useful or of interest :

	[redacted] Epsom and St. Helier University Hospitals NHS Trust The Health and Safety Executive Members of the Jury. 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	**15th February 2016** **Alison Hewitt**