REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. CARE QUALITY COMMISSION** **2. NATIONAL HEALTH SERVICE ENGLAND** **3. CHAIR AND MEMBERS OF MENTAL HEALTH NATIONAL PROGRAMMES OF CARE BOARD, NATIONAL HEALTH SERVICE ENGLAND** **4. HOSPITAL DIRECTOR, PRIORY HOSPITAL, ROEHAMPTON**
1	**CORONER** I am Karon Monaghan QC, Assistant Coroner, for the coroner area of London Inner West.
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** On 30th September 2013 an investigation was commenced into the death of Francesca Whyatt (date of birth 18th September 1992) and concluded at the end of the Inquest on 4th August 2017. The Jury came to a narrative conclusion. Their conclusion included findings that: (1) The protocols, procedures and risk assessments were not updated to reflect the challenges and changes to the Emerald Ward. The layout of the ward over four floors and the system of fob and key doors made the policy unworkable with the level of staff provided. (2) The zonal observation policy failed and staff were unaware of how it operated. (3) Prohibited items of ligature were not strictly monitored or controlled. (4) On the day of the incident there was a complete lack of leadership, there were very few experienced staff on duty, several were new or with only days of experience on the ward. (5) The training and induction of staff was generic and not fully suited to the particular requirements at the Emerald Ward. The reliance on agency staff added to the risk and detracted from the continuity and effectiveness of the therapy of the ward. More could have been done earlier to recruit permanent staff. (6) Francesca Whyatt's death was contributed to by neglect in that she was permitted to wear tights. (7) Francesca Whyatt's death was contributed to by neglect in that she was able to ascend from the garden to the first floor unrestricted by a locked door and/or staff intervention. (8) Francesca Whyatt's death was contributed to by neglect in that there were no zonal or intermittent observations undertaken between the period 4.05 p.m. – 4.20p.m..

4	**CIRCUMSTANCES OF THE DEATH** Francesca Whyatt was admitted to the Priory Hospital, Roehampton on 20th March 2013 under section 3, Mental health Act 1983, to its specialist Personality Disorder Unit, East Wing (thereafter known as "Emerald Ward"). The unit provided NHS commissioned services to patients requiring specialist care from all over England and Wales. Many of the patients in the Emerald Ward were at high risk of serious self-harm and all required complex and expert care. Emerald Ward was arranged over four floors (basement, ground, first and second), each separated by a single staircase. Observations of patients were primarily carried out "zonally" so that a member of staff was allocated to each floor to observe patients, save that in the case of the first and second floor, a single member of staff was allocated to undertake observations on both floors. In addition, patients were sometimes subject to closer observations (intermittent, 1:1, 2:1) where heightened risk was identified. The doors between the basement, ground and first floor were expected to be locked at all times with access granted to patients by a member of staff using a "fob" key. There was no locked door between the first and second floors. Francesca Whyatt was at known risk from ligatures. A risk assessment ("risk management self-harm plan") was prepared shortly after her admission to the Emerald Ward indicating that she should not have tights or belts. This was because it was understood that she was more likely to self-harm with these items. On 16th April and 17th June 2013, Francesca Whyatt gained access to tights and fashioned ligatures out of them and tied them around her neck. On 6th August 2013 Francesca Whyatt used a belt cord from a dressing gown to which she had been provided access, and tied it tightly around her neck. She was discovered cyanosed and with a nosebleed. This was recognized to be a "near - miss". This incident at least should have been treated as a serious untoward incident (SUI) and as such a formal SUI investigation should have been undertaken. The Incident Form that was used to report the incident described the level of harm as "low" and no investigation took place. On 25th September 2013 at a time between 4.05 p.m. and 4.20p.m., Francesca Whyatt was able to ascend from the basement to the top floor, through doors which were unlocked though expected to be locked, without being observed. She was then found unconscious in a lounge on the top floor of the Emerald Ward with a pair of tights around her neck secured tightly as a ligature. Attempts were made to resuscitate her at the scene. She was then taken to Kingston Hospital where she died on 28th September 2013. The medical cause of Fancesca Whyatt's death was: 1a. Irreversible cerebral anoxia 2b. Upper airway obstruction Emerald Ward closed in June/July 2014. East Wing is now a 12 - bedded female acute mental health ward with the majority of patients diagnosed with psychosis and some are at high risk of self-harm. The NHS funds the care and treatment of the majority of the patients on East Wing through commissioning arrangements. East Wing remains a single ward arranged over four floors, with one floor now inaccessible to patients without supervision. There are no locked doors impeding access to and up the staircases between floors. There has been no risk assessment of

	the configuration of the ward over four floors. Agency staff are still used (though in much fewer numbers). They must complete an observation competency checklist when they commence work on the ward. There is no written or other formal guidance on the frequency with which ad-hoc agency staff must complete the checklist. Ligature incidents are not automatically treated as SUIs. There is no clear guidance or criteria on the circumstances in which a ligature incident/s (or other self-harming incident/s) should be treated as an SUI such as to trigger an SUI investigation.
5	**CORONER'S CONCERNS** During the course of the Inquest, my inquiries 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 has been no risk assessment of the configuration of the East Wing ward over four floors. (2) There is no written or other formal guidance on the frequency with which ad-hoc agency staff should complete the observation competency checklist. (3) Ligature incidents are not automatically treated as SUIs (though the evidence suggests that death can occur within seconds of a ligature being applied). (4) There is no clear guidance or criteria on the circumstances in which a ligature incident/s (or other self-harming incident/s) should be treated as an SUI such as to trigger an SUI investigation.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action. **It for each of the individuals or agencies to whom this report is addressed to identify any specific and appropriate action that should be taken on their or their organisation's behalf in relation to the concerns listed above.**
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 16th October 2017. I, the Assistant 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: (1) The Family of Francesca Whyatt (2) The Priory Hospital, Roehampton (3) [redacted] (4) The Health and Safety Executive

	(5) The Metropolitan Police Service (6) [redacted] (7) [redacted] (8) [redacted] (9) [redacted] 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	**21st August 2017**  **Karon Monaghan QC** **Assistant Coroner, Inner West London**