Regulation 28: REPORT TO PREVENT FUTURE DEATHS

.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

Chief Executive
Norfolk & Suffolk NHS Foundation Trust
Hellesdon Hospital
Drayton High Road
Hellesdon
Norwich
NR6 5BE

1. CORONER

I am Jacqueline LAKE, Senior Coroner for the area of Norfolk

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 14/06/2021 I commenced an investigation into the death of Tracy Dawn WOOD aged 40. The investigation concluded at the end of the inquest on 07/04/2022. The medical cause of death was:

1a) Hypoxic Brain Injury
1b) Cardiac Arrest
1c) Asphyxiation
1d)
2 Personality Disorder

The conclusion of the inquest was: Misadventure.

4. CIRCUMSTANCES OF THE DEATH

Tracy Wood had a diagnosis of Borderline Personality Disorder and a history of self-harm and suicidal ideation. Tracy was admitted to Hellesdon Hospital in February 2021 as an informal patient for a proposed period of two weeks. Suitable alternative accommodation in the community was not able to be identified for Tracy until May 2021. A Behavioural Support Plan was put into place which included one to one talk time for Tracy with staff and she had regular psychological therapy. On 31 March 2021 Tracy [redacted] and a note was put onto her records " *Tracy is not to be given a* [redacted] *due to risk of* [redacted]". The importance to her of one to one talk time was also highlighted in the records. On 1 June 2021 Tracy was given a [redacted] before she went for a visit in the community, on the understanding it would be taken back on her return. The [redacted] was not taken back. No record was made of the decision to give Tracy a [redacted]. At 20.53 hours Tracy called the ward phone and told staff she required help. On going to her room Tracy was found with a [redacted] as [redacted]. Tracy was assessed and said she had not intended to die. There were many meetings with Tracy the next day. There was no evidence as to in depth discussion between professionals with regard to the incidents the previous day. During 2 June 2021 Tracy presented as anxious and agitated and complained of shortness of breath. Her observations were taken on four occasions. Tracy was seen for a consultation with regard to her physical health at 20.47 until 20.48. Tracy closed the door to her room at 20.58.34. At 21.13 hours Tracy was found in her room unresponsive with a [redacted]. Emergency services were called and Tracy was taken to Norfolk and Norwich University Hospital. Her prognosis was poor and Tracy did not regain consciousness. Tracy died on 3 June 2021. There was no evidence that Tracy intended to die as a result of her actions

5. 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 could 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. Tracy Wood was placed on Yare Ward, an acute ward which was staffed in accordance with "Safer staffing levels". We heard that additional staffing could be requested if necessary. The ward was described by witnesses as "busy" and at times "chaotic". Staff were not always available to give Tracy one to one talk time which was recognised as being important to her and for her mental wellbeing, so much so a note was placed in red and bold on her SBAR records "*If we are allocated to TW 1-1 we need to make sure we are doing it, she needs consistency*". Evidence was heard that steps are being taken to recruit more staff and also to retain existing staff and that this is a national problem. The evidence was that the staffing levels are still not sufficient and that recruiting staff remains a problem
2. Following Tracy [redacted] on the evening of 1 June 2021 the Duty Psychiatric Doctor was called to attend to see and assess Tracy, but did not attend. She was assessed by nursing staff but she was not seen by a Psychiatric Doctor as requested by them, until the next morning during a review meeting
3. Tracy [redacted] on 30 March 2021 and a note was placed on her SBAR records in red and bold "*Do not give Tracy* [redacted]". On 1 June 2021 Tracy was given a [redacted], at her request, before leaving the ward for a community visit. Evidence was heard that following a "risk assessment" it was acceptable for this decision to be made by a Band 6 Nurse when the [redacted] was used off the ward and not on the ward where the original [redacted] incident had occurred. The instruction not to give the [redacted] did not specify whether this applied on or off the ward. There was no discussion with a Doctor or any other clinical staff when making this decision. There was no record of the [redacted] being given to Tracy in the written records and no record of the rationale for the decision being made
4. Part of the Risk Assessment for giving a [redacted] to Tracy was that she was to hand the [redacted] back on her return to the ward. Tracy did not return the [redacted] and was not asked to return the [redacted]. That Tracy had been given a [redacted] was overlooked on her return.
5. Following Tracy [redacted] on the evening of 1 June 2021, there was no investigation as to where she obtained the [redacted], despite there being a bold, red instruction in the SBAR records that Tracy was not to be given a [redacted]. By the date of the inquest some witnesses were still unaware as to how Tracy had come by the [redacted] with. Some witnesses were still unaware as to what Tracy had used as a [redacted]
6. Following Tracy [redacted] on 1 June 2021, there was a review meeting and then a Multi Disciplinary Team Meeting. She had a meeting with the Psychologist later that day. No evidence was heard that there was a review of her hourly observations
7. Written records did not specify correct dates and times as to events, for instance the Event Date/Time of the [redacted] incident on 1 June 2021 at 20:53 hours is recorded in the Clinical Notes as "02 Jun 2021 06:49". Tracy's date of death is recorded as 5 June 2021 and her date of birth in the SBAR records is recorded as 1 May 1981, when it is the 1 June 1981.
8. Certain events are not included in the records, for example that a [redacted] had been given to Tracy on 1 June 2021 on her going off ward, contrary to the instruction contained in the SBAR records and of 121 Talk times with Tracy. Evidence was heard that steps are being taken to improve record keeping. However this matter has been raised with NSFT previously and evidence from one witness at the inquest was that not "every discussion" with a service user is recorded in the Clinical Record and that entries are made by one allocated person on a shift who will be told orally what to put by members of staff. This witness had had a 30 to 40 minute one to one meeting with Tracy the day prior to her [redacted] on 1 June and talk time with Tracy on the day following her [redacted] on 1 June, details of which may have been helpful to other staff and regarded of some importance to Tracy's care
9. On Tracy being found on the 2 June 2021 with a [redacted] around her neck, emergency life-saving equipment was not brought immediately to Tracy's room. Monitoring equipment was obtained by a member of staff who gave evidence they were unaware Tracy was not breathing. On return to Tracy's room the emergency "crash bag" was then requested and obtained.
10. A draft Patient Safety Incident Investigation Report (PSII) has been prepared. Evidence was heard that this is now used rather than a Serious Incident Requiring Investigation Report and

has the advantage of being "more timely" and providing more learning. The report was still in draft form at the date of the inquest (nine months following Tracy's death) and the draft was only available to me on the morning of the first day of the inquest, despite assurances at Pre Inquest Review Hearings that it would be available prior to the inquest.

11. The PSII Report contains many inaccuracies including Tracy's date of death, stating it to be 5 June 2021. The report refers to Tracy [redacted] again at 21:00 on 3rd June 2021. The correct date is the 2 June 2021
12. The PSII report refers to the notes of the incident on 1 June 2021 that Tracy [redacted] with a [redacted] but goes on to say that in interviews a cord from her [redacted] was used. Confusion remained as between the events on the 1 June 2021 and the 2 June 2021. The report refers to the view of the MDT meeting on 2 June was to keep Tracy on hourly observations. There is no reference in the Clinical Notes to observations being discussed. Witnesses asked about observations at the inquest could not recall observations being discussed or that they were not discussed.
13. The PSII did not involve interviews with members of staff who had involvement with Tracy in the hours and days prior to her death, including staff who gave the [redacted] to Tracy and a Nurse who had regular involvement with Tracy's care and who knew her well
14. The PSII stated that statements of members of staff "for the Coroner" were reviewed. However many of these statements contained inaccurate dates and times including the date of death.
15. The PSII does not make findings with regard to areas of concern raised at the inquest such as with regard to Tracy being given a [redacted] on the morning of 1 June 2021 despite there being a bold red note contained in the records that Tracy should not be given a [redacted], that this was not discussed with any other senior member of staff, no record was made of the decision and the rationale for the decision, nor that the [redacted] was not returned on Tracy's return. The PSII does not include reference to inaccurate record keeping and full records of important events not being kept.
16. The first draft of the PSII Report contains a sentence "*However, staff noted there was a lack of clinical or management leadership supervision on the ward at the time and they were often left to "firefight" with patients who they perceived carried a greater level of acute risk than Tracy."* This view of staff was not included in the final draft Report

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 03 June 2022. 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:

[redacted], Parents
Care Quality Commission

I have also sent it to:

Department of Health
HSIB
Healthwatch for Norfolk

who may find it useful or of interest.

I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

I may also send a copy of your response to any other person who I believe may find it useful or of interest.

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.

9. Dated: 11 April 2022

Jacqueline LAKE
Senior Coroner for Norfolk
Norfolk Coroner Service
County Hall
Martineau Lane
Norwich NR1 2DH