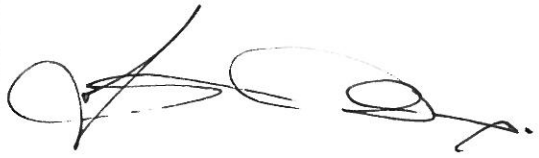
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Head of Mental Health Commissioning,** **NHS England,** **Surrey and Sussex Area Business Team,** **Business Office,** **York House,** **18-20 Massetts Road,** **Horley,** **Surrey.** **RH6 7DE.** [redacted] **Mr Ken Wilson,** **Chief Executive Officer,** **Cygnet Health Care,** **22, Crofton Road,** **Ealing.** **W5 2HT.** **Mr Bob Deans,** **Chief Executive,** **Kent and Medway Mental Health Directorate,** **Trust Headquarters,** **Farm Villa,** **Hermitage Lane,** **Maidstone,** **Kent.** **ME16 9PH**
1	**CORONER** I am Dr Fiona Wilcox, Senior Coroner, for the coroner area of Inner West London
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 17th April 2013 I commenced an investigation into the death of **Lisa Marie Inkin aged 21years.** The investigation concluded at the end of the inquest on 16th January 2014. The conclusions of the inquest were as follows: ***Injury or disease causing death:*** **I(a) Multiple trauma** ***How, when and where Ms Inkin came by her death:***

	Lisa suffered with severe anorexia nervosa and at the time of her death was on home leave from Cygnet Eating Disorders Unit in Ealing. On 9/4/2013, instead of returning to the ward as planned to attend a CPA meeting, she dived in front of a train at Victoria Station at approximately 10:30am. She sustained multiple injuries and was recognised as life extinct at the scene. She had sent letters and texts expressing her intention over 8/4/2013 and 9/4/2013. ***Conclusion of the coroner as to the death:*** **She took her own life whilst suffering with anorexia nervosa**
4	**CIRCUMSTANCES OF THE DEATH** Lisa took her life whilst travelling from her home in Kent to an Inner London treatment unit, to which she had been referred due to lack of local specialist inpatient services for eating disorders, Cygnet Eating Disorders Unit in Ealing, to attend a CPA meeting. Had the unit been local, her mother may have been able to accompany her and the death averted. Throughout the course of her illness, she had been repeatedly referred out of area for specialist eating disorder services and once to a general adult psychiatric unit all because of a lack of local inpatient services. There was evidence taken of poor communication between the local community follow up services and the out of area secondary in-patient provider at points through out her psychiatric care, such that follow up had not been organised post discharge despite the obvious need for the same. Evidence was also taken that a friend of Lisa had passed on concerns about Lisa's suicidal intent to the ward at Cygnet, but that this information was not appropriately acted upon until too late to take any preventative action. The evidence of Lisa's psychiatrist was that the minimum that should have been done was for Lisa and her mother to have been contacted when this information was received by the ward, which was the day before the incident. She had not known that such information had been passed to the ward until she was writing a report following Lisa's death. The evidence of Lisa's mother was that had she been made aware of Lisa expressing suicidal ideation she would not have let Lisa travel back alone. It was of note that Lisa had a past history of serious suicide attempts and before each had expressed suicidal ideation in a similar manner. This failure to act upon the information received on the part of the ward staff may have contributed to the death. Telephone record analysis was presented to the court which confirmed that the day before her death, Lisa had attempted to call the ward at Cygnet on multiple occasions, but there was only a record of one conversation with the ward staff. It was unclear whether the staff on duty the day before the incident had received any other calls and therefore it was speculation only as to whether there was any further lost opportunity to prevent this death. Evidence was also taken during the course of the investigation that there will no longer be any specialist in patient service for eating disorders in Kent and that instead an out-patient treatment service is to be established that involves the daily collection and drop of those suffering with eating disorders to a day centre service but no overnight care. Grave reservations about the effectiveness of such a service for patients such as Lisa were expressed by various relevantly experienced health care professionals, with difficulties anticipated in transportation and the lack of overnight supervision.
5	**CORONER'S CONCERNS** During the course of the investigation the evidence 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. The shortage of local General Adult Psychiatric in-patient beds. 2. The complete lack of any local in-patient specialist eating disorder beds.

	3. The communication between local services and out of area providers of psychiatric care. 4. The lack of overnight supervision of patients being treated for eating disorders in Kent. 5. The possibility of transport difficulties with potential problems on pick up such as refusal to leave the home address, not being ready at the appointed time etcetera, spending more time in transport than in therapy. 6. The failure on the part of the ward staff at Cygnet to appropriately escalate the information that they received about suicidal intent on Lisa's part until the day after the information was received and it was too late for any preventative action to be taken. 7. Potential failures either to record calls taken from patients by the ward or insufficient staff on duty to answer the phone to patients. 8. Possible lack of training or experience on the part of Cygnet ward staff to understand the importance of receiving information about suicidal intention of one of their patients. 9. Possible lack of training or experience on the part of ward staff at Cygnet as to when and how to escalate information about suicidal intent expressed by a patient. It for each of the 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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 10th April 2014. 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] [redacted] Consultant Psychiatrist, Cygnet Hospital, 22 Crofton Road, Ealing, London. W5 2HT. [redacted] Hospital Manager, Cygnet Hospital, 22 Crofton road,

	Ealing, London, W5 2HT [redacted] Patient Safety Manager, Trust Headquarters, Farm Villa, Hermitage Lane, Kent. ME16 9PH. And the **Care Quality Commission** who may find it useful or of interest. 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	**13th February 2014**  **Dr Fiona Wilcox** **HM Senior Coroner Inner West London.**