REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Affinity Healthcare Ltd (The Priory Hospital, Cheadle Royal) **2.** Manchester Mental Health & Social Care Trust 3. Central Manchester University Hospitals NHS Foundation Trust 4. Greater Manchester West Mental Health NHS Foundation Trust 5. Department of Health, London 6. Faculty of Child and Adolescent Psychiatry, Royal College of Psychiatrists
1	**CORONER** I am Ms L J Hashmi, Assistant Coroner for the coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 8th January 2013 I commenced an investigation into the death of Miss Samiyo Sahra Shiih Farah then aged 17 years of 1 Outringham Drive, Openshaw, Manchester. The investigation was concluded at the end of the inquest on the 16th April 2014. The conclusion of the jury at inquest was that the deceased killed herself whilst suffering from depression and was combined with a brief narrative. The medical cause of death was 1a) Pressure to the Neck
4	**CIRCUMSTANCES OF DEATH** Briefly and by way of background, the deceased was a highly articulate and intelligent young woman who had moved to the UK with her family in around 2004. She had a history of self-harm since the age of 14. On the 30th October 2012, Miss Farah consulted her GP who diagnosed depression. On the 31st October 2012, she was admitted to the A & E department having taken an overdose of paracetamol. She was subsequently transferred to an adult MAU under the care of Registered General Nurses for medical treatment of the overdose. Miss Farah was seen on admission by the nurse-led Mental Health Liaison team (MHL). This was said to have been the process in place within the trust at the material time. The deceased was not therefore referred directly to a Consultant Psychiatrist for assessment. The MHL nurse appraised MAU staff regarding Miss Farah's presenting condition and advised that if they had any concerns regarding the her mental health, then further contact could be made (with the MHL team). The MHL nurse did not see the deceased again until discharge on the 8th November, although she participated in a multi strategy meeting in the interim. Anti-depressant therapy was not instigated (this would necessarily have required the involvement of a member of the medical psychiatric team) - on the basis that medication was only one of a variety of

types of treatment.

During the course of her admission, the deceased made allegations against family members which triggered a safeguarding investigation. This necessitated the involvement of the multi-disciplinary team. The allegations made were unsubstantiated and the deceased was discharged home with a plan of care in the community (Child & Adolescent Mental Health Team – 'CAMHs' - and intensive home treatment team). A children's social worker was involved in the discharge planning process, however it was unclear what/how many different discharge options were made available to the deceased at this time.

Whilst on the face of it Miss Farah appeared more settled following discharge, her family felt that she continued to demonstrate uncharacteristic behaviour.

On the 26th November 2012, the deceased's mother discovered that her daughter had purchased a large number of paracetamol and cocodamol tablets. She called for an emergency ambulance. Miss Farah was described as appearing 'happy' at the prospect of readmission.

Miss Farah was seen by doctors at the same A & E department whereupon she was referred to a Psychiatrist for assessment. Whilst the decision to refer directly to a physician was no doubt wholly appropriate, it was 'at odds' with the previously identified referral process (MHL) – particularly bearing in mind the circumstances surrounding admission on each occasion.

Nonetheless, the deceased was diagnosed as suffering from marked depression with suicidal ideation. Arrangements were therefore made for her to be admitted directly to an adolescent mental health unit on the 27th November. The only bed available at the time was in the private sector. This bed was commissioned with the proviso that as soon as an NHS bed became available, the deceased would be repatriated. The Child and Adolescent Mental Health team ('CAMHs') became involved and a lead practitioner was identified.

Following admission, the deceased was placed on 1:5 observations. A STAR Risk Assessment was initiated following admission and completed subsequently. A key nurse was allocated but she went on leave very soon after the deceased's arrival. There was conflicting evidence regarding whether associate nurses were used/allocated and at what grade (the associate acting in the absence of the key nurse).

Between the 13th and 15th December 2012 Miss Farah self-harmed by ligature (shoe laces) twice and was found head-banging against a wall. She remained on 1:5 observations. The STAR risk assessment tool was not updated at the time, nor was it updated prior to repatriation.

A bed became available at the NHS hospital sometime after the 17th December. Miss Farah was unhappy to transfer to another unit as she had started to form therapeutic relationships with staff and felt safe where she was, on 1:5 observations. She made her views known to those caring for her.

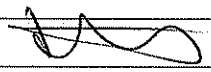
On or around the 18th December, the Dr in charge of Miss Farah's care formed the view that it was clinically preferable for her to remain. He allocated the task of contacting the Commissioners to the staff nurse on the ward round. This, it was subsequently conceded, was inappropriate and that contact with the Commissioners should have been tasked to a senior manager or have been the responsibility of the clinician himself. The ward round ended late, by which time the funding office (who held the contact details for the Commissioners) had closed. The staff nurse maintained that as he was unable to contact the Commissioners, he rang the NHS unit directly in order to put forward both the patient's view and the clinical preference of the Dr - only to be told that the transfer was to go ahead the next day.

Communication between CAMHs, the private hospital and NHS provider was limited to say the least. The CAMHs lead was not advised of Miss Farah's wish to stay at the private unit, the date of her transfer or the self-harm incidents of the 13th to 15th December. Had he been made aware of her views and the clinical preference of the Consultant, then he would have 'escalated' matters to his manager.

Miss Farah was transferred to NHS care on the 19th December. En route, the escorting Health Care Assistant (HCA) purchased shoe laces for the deceased from the shop next to the NHS unit with, he maintained, the full agreement and knowledge of the discharging staff nurse. This was so as to ensure the patient's dignity.

The escorting HCA maintained that he handed over the transfer documentation and gave a brief verbal handover to a nurse on the accepting unit. This handover included bringing the recent purchase of shoelaces to their attention.

	The staff at the NHS unit maintained that they were not advised of the ligature/self-harm incidents of the 13-15 December and that had they been told, they would i) have questioned the appropriateness of the deceased's transfer and ii) had the transfer been agreed, that this information would have materially altered their plan of care for the deceased. A STAR risk assessment was completed by the Occupational Therapist following admission. The deceased was later seen by the junior Dr and placed on 1:15 observations following discussion with the Consultant. It was subsequently conceded that a call ought to have been made to the transferring unit to enquire as to why the deceased had been on 1:5 observations for 22 days prior to transfer as this was unusual. Initially, Miss Farah was placed on the 'acute corridor' (three young people were in residency at the time, with two staff). After a short period, she was transferred to the main ward area. On the 23rd December 2012, a search was conducted of Miss Farah's room, along with the rooms of two of her peers. The deceased had allegedly been passing 'contraband' to others within the unit. Items found within the deceased's room included strips of material (taken from an item of her clothing), two pairs of shoelaces (one set hidden under a bed pillow), broken CDs and a plastic bag was found hidden upon her person (the deceased had previously researched the use of 'exit bags' as a way of self-harming). The contraband items were confiscated. The deceased was allowed to keep her clothing and was kept on 1:15 observations. The STAR risk assessment was not updated until the 28th December. Key staff/managers were however notified via the 'Datix' system, save for the Consultant responsible for Miss Farah's care (he was a locum at the time and was not included within this notification process). He was told of the incident the following day and observed Miss Farah on the ward (no direct patient contact). The patient observation rate remained 1:15. On the 30th December 2012, a unit search was directed by senior managers. At 09:30 a nurse entered Miss Farah's room but could not wake her. He called for a female member of staff to assist before approaching the deceased. Miss Farah was found unresponsive in her bed with a (non-suspension) ligature around her neck. The ligature had been constructed from shreds of fabric from her clothing. CPR was commenced and paramedics summoned. Life was confirmed extinct at 10:02 on the 30th December. During a search of the deceased's room by police after her death, a serrated drink can was discovered hidden in the deceased's bag. The SIO believed that this item may have been used to create the shreds of clothing used to form the ligature.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest 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) Observation protocol - there is no national guidance/policy on the observation of children and adolescents within specialist mental health units. At present, clinicians are forced to adopt/adapt policies applied to adults with mental health issues. The care needs of young people are quite different to those of adults. 2) Communication/contact between transferring establishments - there is no formal policy/protocol in use/between the private sector and the NHS detailing steps that should be taken (and by whom) upon transfer of patients between sectors, thus risking that not all key information (both verbal and written) is properly communicated before, during and after transfer. Whilst progress is being made in this regard at local level following the death of Miss Farah (and may well be the basis upon which any national policy/protocol might be formulated) there is currently no communication/transfer protocol in existence. This also potentially impacts upon all other healthcare sector providers e.g. the acute sector, hospital to care home, acute to rehabilitation/community services etc. 3) There appears to have been an inconsistency of approach following Miss Farah's admissions to A & E. She was referred directly to a Psychiatrist on the second attendance when she was clearly unwell but had not managed to self-harm but was not on the first attendance when she had taken an overdose. This also raises the question as to whether she ought to have been referred (to a Psychiatrist) on the 31st October 2012.

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 Friday 27th June 2014. 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: - Parents of the deceased, through their legal representative - Manchester CCG (via solicitors) - Manchester City Council 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 from. 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	30th April 2014 Signed:  Ms L J Hashmi