REGULATION 28: REPORT TO PREVENT FUTURE DEATHS .

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • The Right Hon. Jeremy Hunt MP, Secretary of State for Health • Professor Sir Bruce Keogh - Medical Director of NHS England • Dr J Hampton – Medical director of The University of South Manchester NHS Foundation Trust ("UHSM") • The NHS CCG's for South, Central and North Manchester • Dr S Colgan – Medical Director of Greater Manchester West Mental Health NHS Foundation Trust ("GMW") • Dr J S Bamrah – Medical Director of Manchester Mental health and Social Care NHS Trust ("MHSC") Copied for interest to: • Coroners Society of England and Wales • Care Quality Commission • Central Manchester Hospitals Foundation NHS Trust • Pennine Acute Hospitals NHS Trust
1	**CORONER** I am Nigel Sharman Meadows, H.M. Senior Coroner for the area of Manchester City.
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	**INQUEST** On 13th December 2012 I commenced an investigation into the death of Kimberley Lauren Lindfield, aged 27. The investigation concluded at the end of the inquest on 30th January 2015. The pathological cause of death was found to be: 1a Hanging I found that the details of when, where, how and in what circumstances the deceased came by his death in section 3 on the Record of Inquest

were as follows:

At about 19.00 hours on 17th July 2012 on Ward A10 of Wythenshawe Hospital, Manchester the deceased, who suffered from a borderline personality disorder and recurrent depressive episodes was an in-patient being treated for a self-administered, deliberate overdose of her medication, was found in bed space no.27 with the privacy curtains substantially, but not completely, closed. She was hanging from a dressing gown cord tied to the top of the privacy curtain rail and she had suffered a cardiac arrest. She was resuscitated and cardiac function was restored but she had suffered severe brain damage and died on 23rd July 2012.

The conclusion of the inquest was a Narrative Conclusion :

The deceased died as a result of a misadventure contributed to by neglect.

There was a serious and significant failure to:

1. Refer her as soon as possible for a mental health assessment upon her admission to hospital after an admitted deliberate self-administered overdose.
2. Adequately, or at all, make appropriate clinical records of her increased level of observations as a result of concerns about her self-harming behaviour.
3. Adequately, or at all, make appropriate clinical records of her interactions with nursing and/or clinical support workers and any indications of continuing suicidal/self harming ideation
4. Assess and take appropriate clinical action to ensure the continuing health and safety of the deceased pending a required medical and mental health assessment.
5. Note that she was recommended to have continuing cardiac monitoring following the ward round carried out at about 15.00 hours on 17th July 2012 and to explain the clinical significance and the need for continuous monitoring to the deceased.
6. Ensure that clinical staff were aware of and implemented the policy of referral for mental health assessment as soon as possible of patients admitted with evidence of suffering from mental disorder and/or after self harming

It was possible that, had the deceased after admission been referred as soon as possible for a mental health assessment, her life would have been saved or prolonged.

4	**CIRCUMSTANCES OF THE DEATH** 1. Kimberley Lauren Lindfield ("Kimberley"), who was born on 3 December 1984, suffered from mental health problems beginning in her teenage years. This resulted in her taking a number of overdoses and self harming. She was eventually diagnosed with an emotionally unstable personality disorder with borderline traits (ICD F60.31) and a recurrent depressive disorder. This is a mental disorder within the meaning of the Mental Health Act 2007, as amended. Over a period of some years she had a number of admissions to psychiatric units. 2. Another very experienced Consultant Psychiatrist took over her care in 2009 and she also had a long and therapeutic relationship with her care coordinator. Over a period of years she had about a dozen admissions to hospital following overdoses. Her condition was such that she was particularly vulnerable to life events and pressures which often resulted in her self harming behaviour to release her inner tensions. Her self harming episodes being precipitated by perceived (real or not) sensitivity to abandonment, rejection and instability in her affect. In the days prior to her death she did not present as suffering from any form of serious mental illness such as schizophrenia but a disorder of her psychological makeup. She was, however, treated with mood stabilizer and anti-psychotic medication. 3. Her self harming behaviour was characterised by ensuring that she sought medical help and cooperated with admission for assessment and treatment. 4. She enjoyed a long and beneficial as well as therapeutic relationship with an organisation known as "42nd Street". This provides help and support for young persons in respect of their mental health up until the age of 26. 5. Kimberley also had a loving and caring family who supported her. However, she was often guarded about disclosing her true feelings and her self harming behaviour was unpredictable with no obvious clues or indications even to her closest family members. 6. By the summer of 2012 she was expressing concerns about a number of issues. There were as follows. Firstly, noisy neighbours who had also been abusive and were causing her distress. Secondly, recent DHS benefit changes meant that although she had been settled in a 3 bedroom flat for some years there was a concern that she may have some of her benefits deducted although her family tried to reassure her that they would make up the difference so that she would not have to move. Thirdly, she had been diagnosed with suffering from fibroids which meant that she was very likely to have to have a gynaecological operation to treat the condition with a risk of her becoming sterile. She had an appointment to see a Consultant to discuss her condition a few days after her final admission to UHSM. Finally, her long association with the 42nd Street organisation had come to an end, although she was keen to still participate in an event run with a local university. She did not find another substitute organisation as helpful.

7. She had enjoyed a period of relative stability and had been looking forward to participating in the event with the University as well as going away for a family holiday.
8. On 25 June 2012 she had been admitted to UHSM after another reported overdose and was treated for her physical condition and was referred for a mental health assessment which took place the following day and the day after. She saw her care coordinator and was also seen by the MHSC CRHT services on a daily basis for some days after her discharge.
9. During the early hours of 17 July 2012 she called for an ambulance and reported to them that she had taken an overdose of her medication. She also had written out a list of what she said that she had taken which accompanied her. In addition she had cut herself on her thigh several times. She was conveyed to UHSM a short distance away and the records suggest she was admitted to the A&E department at shortly before 06.00 hours. She was triaged and seen by a nurse and then the duty Doctor in A & E. He took a history and consulted ToxBase for advice on the clinical management of her condition. Amongst other things it recommended cardiac monitoring for a period of time. She was not referred for a mental health assessment at that stage. Her condition was reviewed by another Doctor at shortly after 08.00 hours but once again this concentrated on her physical condition and she was not referred for a mental health assessment.
10. She was then seen by a senior Doctor at about 09.15 hours (who by the time of the inquest had been appointed as a Consultant) and once again reviewed her. He had just started his period of duty. The plan of her care and management included a psychiatric referral prior to her discharge but also cardiac monitoring for at least 6 hours. This Doctor told the court that he understood and interpreted that she would be seen by the mental health team when medically fit to be discharged from the unit or hospital and not simply when she was fit enough to be seen and assessed by the mental health team. He maintained that in practice based on his experience that there was a considerable degree of reluctance for the mental health team to see and assess a patient until they were medically fit. It was known from the outset of this admission that she had been recently admitted with a similar presentation.
11. At about 10.00 hours she was transferred to ward A10, the Clinical Decisions Unit or what may also be known as the AMU. She was clerked into the ward by a nurse and cardiac monitoring was being undertaken. This was to see if she suffered any abnormal cardiac rhythms as a latent effect of the overdose. She was due to be seen on the ward round later in the day. She also had some MEWS vital signs recorded at 11.00 hours but apart from that there was a paucity of nursing records. I was told and accepted that because of her history of self harm she was subject to a regime of enhanced observations to be conducted every 15 minutes although there was no clinical record of this decision or records of such observations. The nursing staff changed shifts at about 13.30 hours and this was

followed by a handover.

12. Ward A10 which cared for 28 patients was a busy ward staffed by some 6 or 7 Nurses and a number of Clinical Support Workers (CSW). The afternoon shift was led by a senior band 6 Sister who I was told and accepted was content to maintain the same level of observations and directed a very junior and inexperienced nurse to do this. This clinical plan was not recorded and nor were there any records made of such observations. In addition it was not clear precisely what such level of observations should actually entail or what records should be made as a consequence.
13. The junior nurse maintained and I accepted that she did carry out those observations which on occasions involved a glance over from the nearest nurses station to an actual conversation. She accepted that she should have made written records but had failed to do so. The Sister in charge of the ward also accepted that records should have been made and that it was her responsibility to ensure this was done.
14. In any event a ward round was conducted by a Locum Consultant at about 15.00 hours and Kimberley was recorded as being tearful. The conclusion of which was that apart from additional blood tests she should continue her cardiac monitoring for at least another 24 hours and that she should be subject to a psychiatric review the following day. Once again she was not referred for a mental health assessment at that time. The Sister in charge of the ward did not know the outcome of the ward round and did not ensure that she did before being approached by Kimberley and requested to leave the ward to have a cigarette but also had removed her cardiac monitors and was refusing to continue this. The Sister did not know of the clinical management plan but she did speak to the Consultant about her leaving the ward who agreed but with an escort. The Sister did not therefore explain to Kimberley the clinical significance and importance of cardiac monitoring and seeking to persuade her to continue with this.
15. A CSW (employed from an Agency on a regular basis and who was familiar with the ward) was allocated to accompany her and when outside was told by Kimberley that she intended to try to harm herself again. The CSW interpreted this as trying to commit suicide and thought that she may have also mentioned doing this when she got home. She recognised the potential importance of this information but did not record it herself in any records but I accepted that she did tell another member of nursing staff who she was unable to identify. After this at tea time when she was distributing meals to patients Kimberley refused her meal saying that there was "no point". Once again the CSW did not record this but I found that she told another member of nursing staff who once again could not be identified.
16. In the late afternoon another patient was allocated to a bed diagonally opposite from Kimberley's bed number 27. They exchanged some brief conversation and Kimberley was not noticeably upset or distressed. She had the privacy curtains only

partially drawn so as to prevent her seeing the patient in the adjoining bed space who was very ill. At about 18.30 hours she was seen to be on her bed watching TV. At about 18.50 -18.55 hours her bed space now had the curtains almost totally drawn around but for a gap of a few feet.

17. The junior Nurse allocated to monitor her went to check and found her unresponsive and hanging from dressing gown cord tied to the top of the privacy curtain rail. Help was immediately summoned and the ligature cut. CPR was commenced and the crash team called. Eventually cardiac and respiratory functions were restored and she was transferred to the ICU. Sadly, she had suffered irreversible serious brain damage cause by the oxygen starvation to her brain during her cardiac arrest. She died on 23 July 2012. Pathologically she died from 1a. Hanging and there was no evidence of consumption of alcohol or any illicit drugs which could have effected her judgments.
18. No contemporaneous nursing records were made after 13.30 hours apart from her MEWS scores at 16.00 hours. This was clear breach of the code of conduct of the NMC in respect of record keeping. The Police carried out an investigation to rule out criminal or third party involvement and UHSM commenced a Serious Untoward Incident Investigation ("SUI report") which was led by a senior Consultant. However, this did not identify and have statements taken from every member of staff on duty on the ward that afternoon. The Police had received some information about the CSW involvement (see paragraph 15 above) but UHSM did not provide her contact details.
19. I made arrangements to trace and call her as a witness and also had to have the other staff members identified and their recollections obtained. None of the other staff could recollect speaking to the CSW but they were asked well over 2 years after the incident. However, as a matter of fact I accepted and preferred her account of events. However, the Sister in charge of the ward told the court that had she been told about the reported continuing threat of self harm/suicide she would have initiated 1 to 1 observations pending a further medical review and a mental health assessment.
20. I received detailed expert evidence from a Consultant Psychiatrist about her condition and how self harming was a response to her condition. She left no note or other indication of a contemporaneous intention to kill herself. She had no history of ever using a ligature before and had no access to medication. I was satisfied on the balance of probabilities that she died as an unintended consequence of her deliberate act but without the intention to kill herself. I found that her death was contributed to by "Neglect" and that it was possible that had she had a mental health assessment she would not have died or that her life would have been prolonged. I also found that there were a number of serious and significant failures in her care and management.
21. It is with considerable sadness that I have to record that the above events took place after another death at UHSM in not dissimilar circumstances of a man called Paul Dean in 2009. I heard the

	inquest in 2010 and issued a detailed Rule 43 report letter to which UHSM and MHSC responded (copy attached) in which they said that, in accordance with NICE Guideline CG16, they would ensure a common way of working and a referral for a mental health assessment of every patient who presented with evidence of mental illness/disorder and/or after reported self harm/suicidal behaviour. In summary the assurances given were not fulfilled in practice and that the referral for a mental health assessment that Kimberley should have had either in A & E or on ward A10 was not actioned at any time. Furthermore that several members of staff from both UHSM and MHSC, in particular the senior Doctor who saw Kimberley at about 09.15 hours on 17 July 2012 were not aware of the new policy or expectations and were labouring under the incorrect interpretation of what medically fit to be discharged or assessed meant. This was very regrettable and understandably was cause of great distress for the family. 22. The care and management of patients who suffer from apparent mental illness, mental disorder and/or after reported self harm also involves another NHS mental health Trust, namely GMW, which cares for patients who are registered with GP practices in a specific geographical area.
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 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. I am told that all patients presenting with symptoms of mental illness/ mental disorder and/or after reported self harm/suicidal behaviour will now be automatically referred for a mental health assessment to be conducted as soon as possible whether that referral is from A& or any ward. Pending that assessment, mental health staff can give advice by phone concerning the patients interim care and management. Both UHSM and MHSC provided evidence about a joint understanding and approach as well a training and induction of staff. GMW may also be involved in such a case. That was to a very large extent the assurance I was provided after the death of Mr Dean. There were no plans or thoughts to audit whether or not in practice there was an appropriate and timely response to such presentations to ensure that the new system was actually working. In view of the history I am concerned that without such an auditing process failures of care may take place as identified above. 2. Whenever an increased level of observations is initiated pending a mental health assessment because of the concern about a patient's

	mental state and/or self harm/suicidal behaviour there should be a clear written policy or protocol setting out what those observations actually involve (e.g. what 1 in every 15 minutes means and precisely what should be recorded) and the recording of them with a clear chain of responsibility with the obligation on one appropriate member of staff to ensure that this is done. I am concerned that at present such does not exist. 3. I am concerned that there is currently no written protocol or guidance where there is an appropriate clinical review and there should be a change in the care and management plan in response to new or changed circumstances or new risks. 4. I am concerned that all UHSM Nursing and Clinical staff should be reminded of their responsibilities for good quality record keeping as an essential part of patient care and that there are periodic audits of record keeping in similar cases to ensure that appropriate standards are being met. 5. I am concerned that any other NHS Trusts in England and Wales who may have similar policies/protocols or working practices about referral for mental health assessment when a patient is "medically fit" and presenting with apparent mental illness/mental disorder and/or after self harming /suicidal behaviour should be informed about this case and have the opportunity to learn and amend their systems.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 Monday 30th March 2015. 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. • The family of the deceased • University Hospital South Manchester NHS Trust • Manchester Mental Health and Social Care NHS Trust I have also sent it to organisations 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	**2nd February 2015** [redacted] **Nigel S. Meadows** **H.M. Senior Coroner** **Manchester City Area**