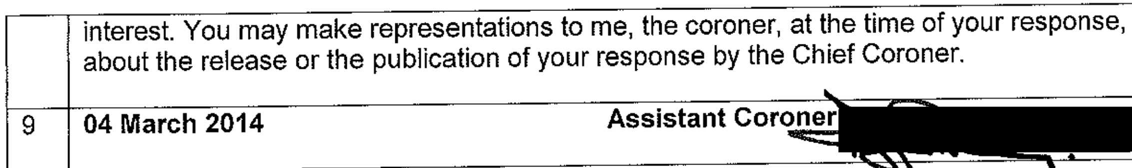
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Care Quality Commission** 2. [redacted] **mother of the deceased** 3. **Avon & Wiltshire Mental Health NHS Trust** 4. **Chief Coroner**
1	**CORONER** I am Dr. Peter Harrowing, LLM, Assistant Coroner, for the Area of Avon
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 28th March 2014 I commenced an investigation into the death of Ms. Kimberley Parsons, age **23**. The investigation concluded at the end of the inquest on 6th February. The conclusion of the jury was that the medical cause of death was 1a) Hypoxic brain injury; 1b) Hanging and the conclusion was that of an Accidental Death.
4	**CIRCUMSTANCES OF THE DEATH** Since 2008 Ms. Parsons had suffered with mental health problems with suicidal ideation. In 2010 she was diagnosed with borderline personality disorder and in May 2010 she was admitted for the first time to Sycamore Ward, Hillview Lodge, Bath owing to suicidal intent. From that time until early 2014 Ms. Parsons took a number of overdoses of medication, self-harmed by cutting herself as well as trying to set herself on fire. Following earlier admissions to Sycamore Ward in August 2013, November 2013 and January 2014 Ms. Parsons was again admitted to Sycamore Ward, Hillview Lodge, Bath under Section 2, Mental Health Act 1983 on 7th March 2014. On admission it was noted that she had a high level of risk of self-harm in the context of a relapse of her mental health condition. Her prescribed medication on admission was mirtazapine tablets 45mg once daily, quetiapine tablets 50mg once daily and lorazepam 1 - 2 mg when required (within the dosage range of the British National Formulary). Ms. Parsons remained very distressed, low in mood and expressing a wish to die. On 9th March 2014 Ms. Parsons self-harmed on the ward by cutting her wrist with broken crockery. The wounds were treated appropriately by nursing staff on the ward. [redacted] Consultant Psychiatrist, reported that Ms. Parsons continued to express strong suicidal desires and was not wishing to engage. On 12th March 2014 the staff nurse noted that Ms. Parsons had again self-harmed on the ward and had used a piece of broken crockery she had found in the garden to make a superficial cut to her wrist. During the early hours of 16th March 2014 Ms. Parsons was found hanging in her room having used an item of clothing as a ligature. Attempts at resuscitation were undertaken by ward staff and the paramedics were summoned. Ms. Parsons was transferred to the Royal United Hospital, Bath where she was admitted to the Intensive Care Unit. However, despite all efforts she died as a result of her injuries on 24th March 2014. Following the incident involving Ms. Parson's and her subsequent death the Trust carried out its own internal investigation which included a root cause analysis. Evidence was given at the Inquest as to the findings of the root cause analysis and these included *inter alia*: 1. Engagement and Observation Forms used on the ward were out of date and not fully completed and lacking the recording of the actual time the observation of the patient

	was carried out. 2. There were changes in frequency and type of engagement and observation during Ms. Parsons' admission. The assessments for these changes were not fully documented and the care plan related to engagement and observation updated. 3. Weekly checks on the resuscitation equipment on the ward were not accurate. 4. The Crash trolley had some items were missing, some items were out of date; items were in the wrong place and additional items not required were present. 5. When the incident occurred only the emergency services were summoned and not the Crash Team as well. 6. The two bank staff involved in the incident had not received the required resuscitation training. 7. Care plans did not outline ranges of evidence based interventions and strategies to support staff to manage the service users acute distress and sleep hygiene. 8. There was a lack of a clear pathway for service users in intensive and inpatient settings with a diagnosis of Emotionally Unstable Personality Disorder During the course of my investigation I became aware that the Trust including Hillview Lodge had been the subject of an inspection by the CQC between 10th - 13th June 2014 although the report of that inspection was not published until 18th September 2014. The report identifies that at the time of the inspection in June 2014 a number of serious deficiencies which had been identified following the incident in March 2014 had still to be addressed by the Trust. During the course of the Inquest the Trust advised that a further inspection by the CQC had been carried out in December 2014 and the outcome positive.
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) That serious deficiencies affecting the safety of patients at Hillview Lodge which had been identified in March 2014 had not been addressed by the Trust by the time of the CQC inspection in June 2014. (2) The CQC should confirm that it is now satisfied that the Trust has addressed all concerns identified at the June 2014 inspection and that they have no further concerns with regard to patient safety. (3) If the CQC are not so satisfied then they should undertake an unannounced inspection of Hillview Lodge at the earliest opportunity.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 29th April 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 [redacted] mother of the deceased, and the Care Quality Commission. I shall send a copy of your response to [redacted] and the Avon and Wiltshire Mental Health Partnership NHS Trust I have sent a copy of my report to the Chief Coroner. 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	**04 March 2014** **Assistant Coroner**