REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Head of Serious Incidents and Complaints, The Policy and Patient Safety Directorate, Suite 12, Phoenix House, Christopher Martin Road, Basildon, Essex, SS14 3EZ**
1	**CORONER** I am Laura Johnson, Assistant Coroner, for the coroner area of East 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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 25 February 2015 I commenced an investigation into the death of EMMA LOUISE BRAY age 25 years. The investigation concluded at the end of the inquest on 26 October 2015. The conclusion of the inquest was the medical cause of death of1a hanging and the conclusion that Emma Bray killed herself, the requisite intention for suicide not being found.
4	**CIRCUMSTANCES OF THE DEATH** Emma Bray ("EB") had a history of problems with mood dating back to her teens. In 2009 she received treatment for an impulsive overdose whilst under the influence of alcohol following a relationship breakdown. She had some contact with mental health services in 2011 and 2013. Towards the end of 2014 EB's mood declined. She had suffered a relationship breakup. Her mood became worse after Christmas. On 6 January 2015 EB was assessed by the Waltham Forest Access and Assessment Team Intake Team ("IT"). She gave details of her history and symptoms and told the social worker that she was on medication prescribed privately. She also told the social worker she was in the process of changing GP surgery. The social worker discussed the case with a psychiatrist in the team and a decision was made to change the anti-depressant medication from Ecitalopram to Sertraline. This recommendation was faxed to the GP. The plan concluded "Emma to be considered for a brief allocation to monitor response to medication." A risk assessment was completed and recorded the risk of self-harm as low. The IT did not take steps to obtain EB's full medication history either from her or from her treating clinicians. No follow up telephone call or meeting was arranged. The referral to the Brief Intervention Team ("BIT") was not made, apparently because of workload. EB's parents then had contact with the IT on 19 January 2015 by telephone when some deterioration in her condition was reported. It was recorded that she would be discussed in the Intake meeting the following day but this did not occur. EB's parents contacted the IT again on 22 January 2015 reporting that EB had no hope she would get better and was pleading with them to end her life. When asked, the parents reported no known concrete plans to self-harm. This information was not placed before the IT MDT or passed on to anyone. On 2 February 2015 EB's mother contacted the IT again. More details were obtained about EB's medication history and the social worker said that an appointment with a psychiatrist needed to be arranged. In the meantime the psychiatrist recommended that the dose of Sertraline be increased from 50mg to 100mg. On 11 February 2015 EB was seen at home by the social worker and psychiatrist. Her parents reported concerns she would kill herself. They reported that she had been

	researching suicide on the internet but said she was not brave enough to do it. Her risk assessment was updated and the risk of self harm was increased to moderate. The Sertraline was changed from night to morning and the psychiatrist recorded different drug therapies he wished to consider. The plan was for a doctor's appointment to review the medication ASAP, for there to be a referral to the psychology panel and for there to be a referral to BIT. The psychology panel referral was made, although the panel that was due to sit on 16 February 2015 was cancelled and EB's case was delayed to the following week. Neither the doctor's appointment nor the BIT referral were made. In the morning of 19 February 2015 EB's father emailed the social worker with a list of symptoms and concerns: "we are of course very concerned as she says she is not going to live her life much longer like this. We also have concerns about her medication as things seem to be getting worse as the increased dose gets into her system". He emailed again at 15.08 on the same day "please call me [redacted] as per last message [redacted] met Emma lunchtime and she is completely withdrawn and unable to interact. I know we have been needy but really must know what is happening and see Emma's health plan with dates." These emails were not entered into EB's notes or indeed ever provided by WFAAT. On the same day EB's mother spoke to another member of the IT who spoke to the psychiatrist. He recommended an increase in the dose of Sertraline to 150my and to introduce Quetiapine. In the early morning of 20 February 2015 EB's father emailed the social worker again informing her that EB had "gone down, down down to the nasty place." EB's mother spoke with the social worker that morning and was told that they would have to wait for the medication to take effect. The plan recorded was for the social worker to refer to the BIT and to [redacted] for EET advice. On 23 February 2015 EB was discussed by the psychology panel. On the same day the social worker referred EB to the BIT. On 25 February 2015 EB hanged herself.
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. – During the evidence I was told that a number of things had not happened that ought to have done: (a) A proper medication history was not taken on assessment (b) EB's treatment and medication history were not obtained from either public or private sector providers. (c) Had EB's history been obtained she should have been referred to a psychiatrist following assessment, to be seen and assessed within 14 days. (d) [redacted] felt that there was an underestimate of the level and complexity of EB's condition. (e) EB remained with the Intake team for the whole period of her contact with the service. This appears to have occurred because of a failure to make a referral rather than because of any positive decision to retain her within the team. (f) EB should have been referred to an appropriate service, probably initially the BIT. This would have provided her with better support and regular monitoring. (g) Even within the IT there was a failure to follow EB up. Telephone contact should have been made with her by seven days after the initial assessment. (h) There should have been regular contact with EB thereafter, initiated by IT. (i) Important information was provided by EB's family about the change in her presentation, most notably on 19 January, 22 January and then from 19 February 2015 onwards. Nothing happened in response to these reports. The information should have been placed before the Intake Team MDT to discuss her care. (j) Had the information been provided EB should have been seen by the team and, in

	response to the information of 19 February 2015 at the latest, had a psychiatric assessment. (k) The emails sent by EB's family were not placed on her notes; accordingly other members of staff looking at her care were not aware of the family's concerns. (l) Risks associated with the drug Sertraline do not appear to have been communicated to EB and her family. Where the drug was recommended by a psychiatrist who had not seen or assessed EB it was unclear where responsibility for advising about risk lay. On a systemic level, the following issues are of concern: (a) Absence of guidelines about what information must be obtained on assessment, including the medical history. (b) Absence of guidance about where that information should be obtained from: the patient / primary sources. (c) A lack of clarity amongst staff about when to retain patients under the IT and when to refer out of intake to other services. (d) Lack of clarity about what contact there should be between patients and the IT. (e) Lack of guidance about what to do when patients are not engaging directly with the IT but there is reason for concern about them. (f) A lack of monitoring / auditing of the passage of patients through the service to see whether cases are being managed and progressed as they ought to be. (g) An absence of guidelines giving staff timescales within which referrals should take place. (h) A lack of appreciation of the need to create a plan with timescales for further treatment / referral to take place. (i) A lack of clear information about the circumstances in which it is appropriate for a psychiatrist to make recommendations about the medication without a full medical history. (j) A lack of clear information about the circumstances in which it is appropriate for a psychiatrist to make recommendations about the medication without seeing the patient in person. (k) A lack of clarity about whose responsibility it is to communicate risks about medication to the individual when the medication is recommended by the WFAAT psychiatrist but prescribed by the GP. This was particularly the case with the Sertraline prescribed to EB, which apparently does have specific associated risks that must be warned of. (l) The lack of apparent process or procedure to ensure that emails sent to staff directly are placed on an individual's notes. (m) Any proper understanding by staff of risk assessment in the context of self-harm. The risk assessment tool in use appeared very basic and not one that provided any real assistance to staff.
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 **4th January 2016** 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] and to the CQC.

	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	**[DATE] 16th November 2015 [SIGNED BY CORONER]** pp