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. Dr Matthew Patrick Chief Executive South London and Maudesley NHS Care Trust (SLAM), Bethlem Royal Hospital, Monks Orchard Road, Beckenham BR3 3BX** **2. Secretary of State for Health, Rt. Hon Jeremy Hunt, Richmond House, 79 Whitehall, London SW1A 2NS** **3. The Chief Coroner,**
1	**CORONER** I am Christopher Williams an assistant coroner, for the coroner area of Inner London South (Southwark Coroners Court).
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. http://www.legislation.gov.uk/uksi/2013/1629/regulation/28/made and http://www.legislation.gov.uk/uksi/2013/1629/regulation/29/made
3	**INVESTIGATION and INQUEST** An investigation into the death of **Christina O'Brien** commenced on the 25/9/2015. The investigation concluded at the end of the inquest on **7th June 2016**. The conclusion of the inquest was that the medical cause of death was 1(a) hanging. The short form conclusion was "Suicide".
4	**CIRCUMSTANCES OF THE DEATH** 1) On the 17/9/2015 the deceased hanged herself, directly outside her flat, using a belt attached to a window handle. She had also made incisions in her arms and legs. A note was found in the flat which made provision for the distribution of her property and the care of her pet dog. The note said at the end "I am sorry". Following a forced entry police found large traces of blood around the flat and in the bath. 2) At the time of her death she had suffered from a long term mental illness described as Schizoaffective disorder for which she was taking her anti-psychotic medication and was capable of understanding the consequences of her actions. 3) The inquest heard evidence that at the time of her death the deceased was receiving treatment and care for her mental illness from the SLAM mental health department. 4) The deceased was first diagnosed as suffering from paranoid schizophrenia in 1984 after she attempted suicide by cutting her wrists. In the following years she was admitted to hospital for psychiatric care on numerous occasions. She was detained under the Mental Health Act on number of occasions. There were also incidents of self harm and suicide attempts between 1984 and September 2015.

5) [redacted] the treating psychiatrist at the time of death gave evidence that the deceased was affected by a spectrum of the following mental health conditions: -

Paranoid schizophrenia; Clinical depression; Anxiety Symptoms including Agoraphobia and panic attacks; Obsessive compulsive disorder; and mood instability.

6) On the 20th January 2015 the deceased attempted suicide by taking an overdose and making a deep incision with a kitchen knife on her left wrist. The wound subsequently required plastic surgery. As a result she was detained for a short period under the Mental Health Act.

7) In February 2015 following discharge from hospital after the suicide attempt, she identified to the mental health team that builders working at her accommodation were "a big stressor".

8) Her sister, [redacted] described, following the discharge from hospital, the on-going building work on the roof of the deceased's flat as extremely noisy and frightening for her. The deceased believed workmen were leaving tools outside her window on scaffolding to encourage her to kill herself. The deceased had also said she feared that the builders were listening in on telephone conversations with her sister.The building work on her flat remained on going and was continuing for several months.

9) In her evidence, which I accepted, [redacted] said that: -

- The deceased was very distressed by the building work at her flat and needed respite from it.
- In the past the deceased had been able to reside at a halfway house [Dove House (women's service) provided by SLAM]. This provided respite for vulnerable people who were not ill enough to be admitted to hospital.
- The Dove House facility was no longer available in 2015.
- After the deceased was discharged from hospital in February 2015 she took refuge from her flat at the home of her boyfriend's mother which was something she did not want as she had difficulties around the idea the idea of family. This had a damaging effect on the deceased's mental health when she returned to her flat after completion of the building work.

10) [redacted] expressed the opinion that had the Dove House option been available during 2015 her sister would still be alive today. The opinion was based on the experience that in the past the deceased had resided at Dove House for short periods and this had a positive effect on her behaviour. The house was not in a hospital setting but in a residential street. She was not detained there and was free to leave if she wished.

11) I also heard evidence from [redacted] on behalf of SLAM who informed me that Dove House closed down about 8 years ago (c.2008) and it was not known whether this was due to funding issues or whether the service was considered not to be effective.

12) [redacted] informed me that, in 2015, the broad treatment options were: -

- Treatment whilst detained under the Mental Health Act 1983.
- Informal admission to hospital
- Home Treatment team attending the patient at home.

13) [redacted] also said that in April 2015 during the building work the Home Treatment team attended on the deceased at home and helped to reduce the level of distress and provided sleeping medication.

14) [redacted] said that the deceased would not have agreed to informal admission to hospital whilst the building works were on going and that she did not like the Home Treatment team attending on her at home. She said there was a gap in the service by not having temporary non-hospital accommodation as a treatment option.

15) A Sudden Untoward Incident (SUI) report, produced by SLAM, addressed the concern of [redacted] in the following terms: -

"Patient A's sister ... pointed out that there was, in her opinion, a lack of available respite for patient A during the period of her building work. She felt that this was an overwhelming experience for her sister which had significantly impacted on her mental state between April and June 2015 ... in the past Dove House had provided a crucial source of support for her sister when she was relapsing and might have proven a welcome alternative to the stresses of her home environment. Unfortunately this service is no longer available and there are presently no other crisis options other than admissions or home treatment"
(page 31 paragraph (8) SUI 23/11/15).

16) The SUI report made the following recommendation: -

"We recommend the CAG reviews the local need for respite care for clients experiencing crises which do not meet the threshold for admission and where Home Treatment is not suitable/appropriate."
(page 32 SUI 23/11/15).

Nb. The initials "CAG" stand for Clinical Academic Group

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 could 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 concerned that the options for mentally ill people in the community needing respite care through SLAM are limited solely to attendance by the Home Treatment team as the alternative to hospital admission. In this particular case I found that the availability of Dove House did, in the past, provide respite for the deceased. I also find, on the evidence I heard, that if this option had been available in 2015 the death might have been prevented. Whilst the Home Treatment team could provide support by way of medication and counselling it could not deal with the source of the distress the deceased was suffering from building work.

(2) Given the unpredictability of the perceptions of people with mental illness in the community I also found that having a further option of respite residence in a non hospital setting could prevent future self-inflicted deaths. Examples that spring to mind, in a high density area like Lambeth, might be bullying by neighbours or sources of excessive noise from neighbouring residences as well as building

	work. (3) I am concerned that the Dove House facility was withdrawn in about 2008 without any provision being made for alternative respite care when it appeared to have had a beneficial effect for the deceased and, by reasonable inference, other SLAM patients. (4) At the conclusion of the inquest, it was suggested to me by the solicitor for SLAM that I should also make a PFD report to Lambeth Social Services as well as SLAM. I indicated at the time that I would consider this option. Having reflected on the matter I have decided not to do this since I consider that the need for respite care is a clinical issue for SLAM in the first instance. If SLAM eventually consider that respite care ought to be available then it is matter for the organisation to decide whether to deliver respite care through its own resources or by liaising with other agencies.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken by SLAM to prevent future deaths and I believe your organisation has the power to take the following action: - 1. Review the local need for respite care for clients experiencing crises which do not meet the threshold for admission to hospital and where Home Treatment is not suitable/appropriate or adequate. 2. Since the respite care residence option was provided in the past, serious consideration should be given to reintroducing this resource as a treatment/rehabilitation option. 3. If when considering the, respite care residence, option it is decided that SLAM does not have the financial resources to provide the facility then in my opinion consideration should be given to liaison with other agencies to ensure provision of the facility when clinically required. 4. When responding to this report a clear indication should be given for the reasons why the Dove House facility was withdrawn in 2009, and in particular whether this was for financial reasons or reasons of clinical effectiveness.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **9th August 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 Person: [redacted] I have also sent it to the **Secretary of State for Health, Department of Health** 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.

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	14th June 2016	**Christopher Williams – Assistant Coroner**