

**In the South London Coroner's Court**

**Inquest touching the death of Rosalind Flett**

**Report to Prevent Future Deaths (*Coroners (Investigations) Regulation 28*)**

	<p><b>THIS REPORT IS BEING SENT TO:</b></p> <p>The Secretary of State for Health, Department of Health</p>
1	<p><b>CORONER</b></p> <p>I am Selena Lynch senior coroner for the coroner area of South London</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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. <a href="https://www.legislation.gov.uk/ukpga/2009/25/schedule/5">https://www.legislation.gov.uk/ukpga/2009/25/schedule/5</a> <a href="http://www.legislation.gov.uk/uksi/2013/1629/part/7/made">http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</a> <a href="https://www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/pfd-reports/">https://www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/pfd-reports/</a></p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 21<sup>st</sup> February 2017 I commenced an investigation into the death of Rosalind Flett The investigation concluded at the end of the inquest on 18<sup>th</sup> April 2018 The cause of Miss Flett's death was due to an incised right internal jugular vein. The jury recorded a narrative conclusion: On 11<sup>th</sup> February 2017 Rosalind Flett was detained under section 2 of the Mental Health Act presenting with emotionally unstable personality disorder and a history of deliberate self harm, at Gresham 1 ward Bethlem Royal Hospital, Beckenham At the time Miss Flett was subject to enhanced arms length observation with thrice daily room and personal searches. However, these measures were not effective in locating any razor blades in spite of five previous incidents of cutting between 27<sup>th</sup> January and 8<sup>th</sup> February 2017. Sometime between midnight and 0100 whilst standing in the common area with the two nursing staff, Miss Flett ran away along the corridor, stopped and using a razor blade to make a deep laceration in her neck in full view of a third nurse. Miss Flett was transferred to King's College Hospital, Camberwell, but died shortly thereafter.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p>

	<p>Ms Flett cut her neck with a razor blade in full view of nursing staff. During her hospital admission she had regularly concealed razor blades in a variety of places, on at least one occasion was known to conceal a blade in her bra. It is not known where she concealed the blade that she used to fatally cut her neck.</p>
5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>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.</p> <p>The <b>MATTER OF CONCERN</b> is as follows. –</p> <p>The Trust's policy on searching was made in accordance with the Mental Health Act 1983 Code of Practice. However, there appeared to be a gap between "an advanced search" which was limited to a pat down of clothing and did not allow for clothing to be removed to underwear, and an "intimate search" which deals with items concealed in a body orifice. Staff were therefore given the impression that they could not ask Ms Flett to remove her bra for searching.</p> <p>Since the conclusion of the inquest I have been informed that the local Trust search policy is to be amended. However, the ambiguity appears to exist in other Trust policies, and I therefore make this report in order to bring the matter to wider attention.</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 20<sup>th</sup> July 2018. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons :</p> <p style="padding-left: 40px;">The family of Rosalind Flett South London and Maudsley NHS Foundation Trust</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>

9	<p><b>DATE</b> 24<sup>th</sup> May 2018</p> <p><b>SIGNED BY CORONER</b> <i>Lucina Lynch</i></p>