Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:
Southern Health NHS Foundation Trust

1 CORONER

I am Grahame Antony SHORT, Senior Coroner for the area of SOUTHAMPTON AND NEW FOREST

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 08/11/2017 00:00 I commenced an investigation into the death of Eleanor Valerie Fyfe BRABANT aged 28. The investigation concluded at the end of the inquest on 05 November 2018. The conclusion of the inquest was:

I a Hypoxic Ischaemic Brain Injury

I b Cardiac Arrest

I c Hanging

II

4 CIRCUMSTANCES OF THE DEATH

Between 00.50 and 01.09 on 2 November 2017 whilst alone in room 7-03 in Trinity Ward Antelope House Southampton, Eleanor Brabant hanged herself. She had suffered with mental illness from the age of about 11 and her most recent diagnoses were Emotionally Unstable Personality Disorder and poly-substance misuse. Her compulsory detention under section 3 Mental Health Act 1983 was rescinded on 28 September 2017 following which her behaviour and mental state deteriorated, but there was no clear care plan then in place On the balance of probability she chose to end her life.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

5.1 It is unclear from the evidence whether the changes made to policies for observations on patients at Antelope House since this death apply to all in-patients cared for by the Trust and what steps have been made to train staff in their implementation, particularly in relation to prioritising the most vulnerable patients.

5.2 Witnesses who gave testimony on the subject were unclear about the need for safeguarding of vulnerable patients who are the victim of crime, such as Eleanor Brabant and their responsibility to report those crimes to the police, whether or not the patient consented.

5.3 It was apparent that the nurses on the ward felt unable to use their powers under section 5(4)

of the Mental Health Act 1983 to prevent patients from leaving the ward even when they had real concerns for the safety and welfare of that person and that they erroneously believed that informal patients were not detainable in such circumstances. The training they had received on the implementation of the Mental Health Act in relation to informal patients had not covered this aspect sufficiently.

5.4 It is Trust policy for the families of patients to be involved in care planning, but where the patient has withdrawn consent for information to be shared with their family, witnesses were unclear as to how this should be implemented, and further training appears to be necessary.

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 11 January 2019. 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 family of Eleanor Brabant (Interested Persons)
and to the Local Safeguarding Board (where the deceased was 18). I have also sent it to Hampshire Constabulary 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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Grahame Antony SHORT
Senior Coroner for
SOUTHAMPTON AND NEW FOREST
Dated: 16 November 2018