C.G.BUTLER
SENIOR CORONER · BUCKINGHAMSHIRE

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, Oxford Health NHS Foundation Trust**
1	**CORONER** I am CRISPIN GILES BUTLER, Senior Coroner for the coroner area of Buckinghamshire
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/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/pdfs/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 5th April 2017 I commenced an investigation into the death of Emma Felicity BUTLER. The investigation concluded at the end of the inquest on 6th December 2018. Article 2 was engaged in relation to this investigation. The conclusion of the jury in the inquest was that the medical cause of death was: 1a Haemorrhage 1b Incised wounds The jury completed a questionnaire which recorded that Emma Butler died at 22:45hrs on 30th March 2017 at Stoke Mandeville Hospital from blood loss as a result of incised wounds inflicted outside the Whiteleaf Centre at approximately 17:00hrs on 28th March 2017. The jury found the following: 1. The change of approach to the care and discharge planning for Emma whilst an inpatient on Ruby Ward during 2017 did possibly contribute in more than a minimal or trivial way to Emma's death. 2. The change of approach to the granting of leave to and the taking of leave by Emma during 2017 did probably contribute in more than a minimal or trivial way to Emma's death. 3. The facts the jury established about the leave taken by Emma on the afternoon of 28th March 2017 did possibly contribute in more than a minimal or trivial way to Emma's death. 4. Emma undertook the act which ended her life. This Report is raised after my having given those representing Emma's family and Oxford Health NHS Foundation Trust opportunity to make written submissions and counter submissions as to Regulation 28 matters arising during the investigation and inquest, and my having received and considered those submissions in the context only of evidence up to the conclusion of the Inquest.

Coroner's Office, 29 Windsor End, Beaconsfield, Buckinghamshire. HP9 2JJ
Tel: (01494) 475505
Fax: (01494) 673760
E Mail: coroners@buckscc.gov.uk

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4	**CIRCUMSTANCES OF THE DEATH** Emma Butler was an inpatient at Ruby Ward, Whiteleaf Centre, Aylesbury under Section 3 of the Mental Health Act. She was subject to restrictions and conditions at various stages in relation to the taking of escorted and unescorted leave from the Centre. The inquest heard evidence about her ongoing presentation, actual self-harm and risk of self-harm in the context of planning for her discharge into the community. In incident of self-harm by cutting occurred in the grounds whilst Emma was on unescorted leave which led to her death at Stoke Mandeville Hospital as a result of blood loss.
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) Access to means of self-harm on the ward. Whilst evidence was given as to the difficulty of reducing access to materials of self-harm without restricting fundamentally the rights and activities of patients, it was clear that incidences of self-harm had, on occasions related to the procuring of, concealment of and use of plastic cutlery available to patients on Ruby for self-cutting. The process appears reliant upon voluntary surrender of such items or on their being found rather than on the monitoring of the handing out and proper return of all such items in the context of use at mealtimes. There is a risk of self-harm within the patient cohort on Ruby Ward. (2) Access to means of self-harm from outside the ward. The processes for searching and seizing potential self-harm material after return from unescorted leave did not prevent items being brought in from the outside at risk to the particular patient, other patients and staff and the evidence regarding the extent of strip or other searches from staff members was variable. The risk of items being brought onto the ward from outside for use by that patient or others remains where the system for searching and the nature and extent of that search has not prevented the introduction of such items. The understanding of and compliance with specific conditions of leave in the context of searches was unclear. (3) General observations. The process for conducting and recording hourly observations left scope for significant variation on the actual time between and the manner in which such observations of a particular patient were undertaken and recorded. There was an indication that this would be reviewed but the risk remains of an incident of planned or spontaneous self-harm occurring between observations for a patient not on a higher level of observations. (4) Urgent or emergency access to the ward phone. The concern remains that a patient

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	on unescorted leave outside the Centre who felt they were going to self- harm or who had self-harmed may not get immediate access to support or assistance by calling the specific ward number given to them. Whilst the evidence indicated the balance between positive risk taking, unescorted leave and taking responsibility for decisions and actions, the risk remains that the safety net is not sufficiently robust to ensure that if such a potentially fatal incident occurs, or is likely to occur, a patient can self-alert the ward and expect to receive an immediate response. (5) Planning for discharge. The evidence indicated the move towards and importance of shorter periods of admission and planning for discharge into the community. However, the process for keeping all aspects under review and communicating decision-making within the team and with the patient was unclear. The potential lack of certainty and structure in relation to ongoing assessment of risk, leave decisions and monitoring of medication effectiveness is of continuing concern in relation to the management of the risks and behaviour of a patient with personality disorder progressing towards discharge.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe Oxford Health NHS Foundation Trust 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 10th June 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 Emma Butler, via their legal representatives. 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	**12th April 2019**

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	Crispin Giles Butler, Senior Coroner for Buckinghamshire

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