REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **NHS England** Chief Executive NHS England Skipton House 80 London Road LONDON SE1 6LH
1	**CORONER** I am Alan Moore Senior Coroner for the coroner area of Cheshire.
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 4 May 2016 I opened an inquest into the death of **Katharine Mary DOWLING** (known as 'Katie'; DOB 17 December 1989). The inquest concluded on 1 March 2019. The medical cause of death following post-mortem examination was: 1(a) Hanging The conclusion of the inquest was a narrative conclusion, as follows: At 10.40 pm on 26 April 2016 Katharine Mary Dowling was found in her room on Beech Ward at Bowmere Hospital, Chester by a member of the ward staff. She had self-ligatured using a ligature formed from a blanket attached to a basin. Resuscitation was attempted by ward staff and paramedics. She was taken to the Countess of Chester Hospital. The prognosis was poor. She deteriorated and she died in the Hospital on 27 April 2016. She died due to the effects of deliberate self-ligaturing; she took her own life. The following factors in relation to her care and treatment contributed to her death: 1. She was under the care of seven consultant psychiatrists during a six month admission; 2. Her bathroom door had been left unlocked when it ought to have been locked; 3. On 26 April her regime for observations by ward staff ought to have been changed to include more frequent observations, in order to reflect an increase in the risk that she might self-harm; 4. There was a lack of clarity towards the purpose of her care and treatment in that it did not adequately address her diagnosis of Autistic Spectrum Disorder (ASD); 5. Only one member of the ward nursing staff had received formal training in autism; 6. The acute ward setting was inappropriate for her care and treatment needs; **7.** There was an absence of appropriate ASD psychology input in her care and treatment.

4	**CIRCUMSTANCES OF THE DEATH** From 2 November 2015 until her death on 26 April 2016 Katie was under the care of Cheshire and Wirral Partnership NHS Trust ('the Trust'). Katie had a range of diagnoses and co-existing mental health issues. She engaged in a variety of different therapies. She had been diagnosed with Autistic Spectrum Disorder (ASD) of the high-functioning Asperger's type on 7 November 2015. A key feature of the evidence at the inquest was the relationship between Katie's co-existing mental health issues and the recognition and integration of her ASD into her care-planning *specifically* and her care and treatment *generally* (see the narrative conclusion above). To be clear, following Katie's death the Trust made a number of significant changes by way of improvements and refinements to practices and procedures, communication and training. Nevertheless some matters of concern remain but these are at a level higher than that which the Trust can properly address.
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: This inquest addressed a specific situation, namely a patient with Autistic Spectrum Disorder (ASD) alongside a co-existing mental health diagnosis. The patient had been treated in an acute psychiatric ward environment for almost 6 months before self-ligaturing with fatal consequences. Notwithstanding that specific context, a feature of the evidence at this inquest - particularly the independent expert evidence of an experienced consultant psychiatrist in this field - was the sufficiency and appropriateness of ASD care planning and care provision and whether there is consistency at a national level. Four discrete themes emerged which merit consideration at a higher level than a single mental health trust: **Guidance** There seemed to be a paucity of clear and accessible guidance to clinicians and ward staff on the relationship between ASD and a co-existing mental health diagnosis / diagnoses. The value of such guidance is that it would signpost strategies to ensure that the ASD element will be properly integrated into a patient's care planning and into care and treatment. **ASD support beyond diagnosis** Expert evidence adduced at this inquest indicated that, nationally, many trusts only provide a diagnostic service in respect of ASD. Consequently, it would appear that there is often no related support or assistance thereafter, including ASD specialist 'psychology' input. The evidence indicated that some Trusts do provide a service beyond the purely diagnostic but the nature and extent of that service varies depending upon geographical location. Consequently it would appear that there is no consistency across the UK.

	Environment ASD-appropriate environments for in-patients diagnosed with ASD and who have a co-existing mental health diagnosis / diagnoses appear to be limited, nationally. If, as a consequence of that, such patients are placed on acute psychiatric wards, potentially for several months (as in this case), they may be at greater risk of suicide. **Training** Expert evidence at the inquest indicated that ASD training, particularly for nursing staff, is not properly understood and is not implemented consistently across the UK in accordance with appropriate national guidelines. Is there a process in place for monitoring and auditing this training? It was the view of the expert witness that intermediate level training ought to be a mandatory requirement for all staff members involved in a clinical relationship with ASD patients.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 **10 May 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 following Interested Persons: 1. [redacted] (Katie's father); 2. Cheshire and Wirral Partnership NHS Foundation Trust; 3. The Countess of Chester Hospital. 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	**14 March 2019** **A G Moore** **Senior Coroner, Cheshire**