**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. The Secretary Of State, Department of Health and Social Care**<br>**2. Chief Executive, Birmingham and Solihull Mental Health Trust**<br>**3. Manager, Camino HealthCare, Oak House, Johns Lane, Tipton, West Midlands, DY4 7PS**<br>**4. Care Quality Commission** |
| 1 | **CORONER**<br><br>I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 21 January 2019, I commenced an investigation into the death of Ms Shannon Quinn. The investigation concluded at the end of the inquest on 4 August 2019. The conclusion of the inquest was a short narrative conclusion of accidental death contributed to by neglect.<br><br>The cause of death was:<br><br>1a Asphyxia<br><br>b Hanging/Ligature Around The Neck |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>i) Ms Shannon Quinn (SQ) was a 24 year old woman with a complex medical history. She had been diagnosed with Asperger's syndrome, anxiety, depression and emotionally unstable personality disorder. She was transferred to the Newington Community mental health team in 2012 under the Birmingham and Solihull mental Health Trust.<br><br>ii) Her treatment was multi-disciplinary in nature and included dialectical behavioural therapy (DBT) and additional input from the personality disorder pathway scheme.<br><br>iii) She had numerous contacts with acute services including the mental health trust home treatment team, and significant history of self-harm and suicide attempts including cutting, overdoses and tying ligatures.<br><br>iv) After a period of admission to hospital under the mental health act from August 2017 to July 2018. She was discharged to Oak House in Tipton outside the local authority area due to unavailability of nearby suitable |

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| | accommodation.<br><br>v) Oak House provides residential and support services with patients for mental health needs and is described as a mental health rehabilitation unit.<br><br>vi) At Oak House, she continued to self-harm including cutting and also use of ligatures.<br><br>vii) She was receiving support and treatment including further DBT and also had an appointed key worker and care coordinator.<br><br>viii) Despite measures put in place, Ms Quinn continued to exhibit risky self-harm behaviour which were described as impulsive and also exacerbated by alcohol. She would self-harm as an emotional release and also to test boundaries to check if staff/people care.<br><br>ix) Information sharing between the Mental Health Trust, care coordinator and Oak House was minimal and not all incidents of self-harm were shared. In addition escalation of risk was not always considered as part of the Multi-disciplinary team (MDT) and Professionals meetings.<br><br>x) In order to manage her risk of self-harm, she was placed on 5 minute observations.<br><br>xi) On the 9 January 2019, she was last observed by staff in her room at 5.55pm and when next checked at 6.05pm she was found hanging. No observation check took place at the scheduled 6pm.<br><br>xii) She was found hanging with a ligature around her neck suspended from the bathroom door handle in her room. Sadly, despite attempts at CPR by nursing staff and paramedics she was pronounced deceased at 6.54pm. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>1. Evidence emerged during the inquest that there was inconsistent sharing of documentation and case notes between the statutory agencies and private sector. In particular, there was no sharing of medical notes/care plans between the Birmingham and Solihull and Mental Health Trust and Oak House.<br><br>2. There was inconsistent and minimal training provided to Oak House staff in respect of managing SQ's complex needs by the Mental Health Trust.<br><br>3. There was a lack of a joint multi-disciplinary/Trust care plan and insufficient contact with the care coordinator due to difficulties in travelling to meet the patient outside the normal Trust area and staff sickness absence.<br><br>4. There was an escalating risk of use of ligatures and incidents of self-harm and little if any measures were introduced to try and provide a ligature free environment.<br><br>5. The patient observation level of 5 minutes was introduced to minimise risk of self-harm but not adhered to. |

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| | 6. Evidence emerged during the inquest that there had been minimal training for Oak House staff in performing resuscitation on patients. The training received included general first aid training by e-learning. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.<br><br>1. All agencies (statutory and private sector) involved may wish to consider reviewing their approaches to sharing of multidisciplinary/agency medical notes and risk assessments for community patients with these complex needs.<br><br>2. Oak House may wish to review its ligature and risk assessment policy and also their policy in determining which patients they should admit as part of their pre-assessment process. They should also consider reviewing their first aid training for all staff including CPR training.<br><br>3. The Mental Health Trust may wish to consider reviewing their policy in discharging patients with complex medical needs as in SQ's case without a community treatment order in place.<br><br>4. The CQC may wish to further review the provider, Oak House and consider whether further inspections are necessary. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 4 November 2019. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons; Family.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **6 September 2019**<br><br>**Mr Zafar Siddique**<br>**Senior Coroner**<br>**Black Country Area** |