REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Clinical Director, Acute Mental Health Services, West London NHS Trust. c/o solicitor advocate for the Trust [redacted] by email
1	**CORONER** I am Dr Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West London
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 the 11th , 12th , 16th , and 27th November 2020, evidence was heard touching the death of Valeria Andrea MUNOZ BIGGS at Inner West London Coroner's Court. She had died on 20th September 2019 after jumping in front of a train at Holland Park Underground Station. She was 31 years old at the time of her death. **Medical Cause of Death** I (a) Multiple Injuries **How, when, where Ms Munoz Biggs came by her death:** On 20th September 2019, Valeria jumped in front of a Westbound train at Holland Park Station at approximately 13:20. She was killed instantly. She had suffered with affective disorder since age 18 years and had received treatment for this successfully in Chile, including in the Spring of 2019. In September of 2019 she developed an exacerbation of her symptoms. She contacted her psychiatrist who recommended increasing quetiapine to [redacted] and restarting clonazepam which had previously assisted. On 12/9/2019 she was actively suicidal and sought help on the advice of her psychiatrist of NHS services. [redacted] attended, which in turn spoke to the Single Point of Access for West London Mental Health Trust. Her symptoms were not taken sufficiently seriously. She attended A&E where she was found by Liaison Psychiatry to be mentally unwell and admission was discussed. She was concerned about admission and so was referred to the CRISIS Home Treatment Team, with a recommendation for low threshold for admission if her risk escalated or her family were not coping. She was directed to Care in the Community by the Home Treatment Team. Overnight she was actively suicidal, attending a train station with thoughts of jumping before a train. This continued the next day. The Home Treatment Team did not visit on

	13th September 2019 as planned and did not assess her suicidality or speak with the family, despite a contact from police that afternoon, informing them that a member of public had found her wandering expressing a wish to take her own life. I find this to be gross failure on the part of the Trust. Suicidal thoughts continued especially on the 15th September 2019. These were underestimated by the visiting team.. By the 15th September 2019, she had left the flat with the intention to take her own life on four occasions. The family were unable to keep her safe. There were delays in psychiatric assessment, failure to increase her drugs adequately and persistent underestimation of her suicidality and failure to adequately engage with and listen to the family and note their concerns. There was team culture of positive risk taking. If she had been adequately assessed and admitted to hospital, her death would not have occurred at this time. **Conclusion of the Coroner as to the death:** Valeria took her own life whilst suffering agitated depression possibly on the bipolar spectrum. Her death was contributed to by neglect.
4	Extensive evidence was taken in court. The findings on the Record of Inquest, as set out above, in many ways highlight concerns. In Addition: There were concerns about the credibility of some of the evidence given by the Trust witnesses, and the ability of the Trust to reflect upon and learn lessons from this death. There was a repeated theme of lack engagement with those attempting to care for Valeria at home; a lack of support for her carers; not recording concerns raised by carers; specifically missing opportunities to make a fully informed assessment of Valeria's risk of suicide; missing opportunities to be updated about her past psychiatric history etc. Valeria was not properly offered admission to hospital, but rather pushed toward care in the community and this decision was never re-visited during the episode of care despite the difficulties in manging her safety at home; her lack of improvement and even apparent worsening; her strong family history of bipolar affective disorder and the strong possibility that this was her underlying diagnosis; and her active risk of suicidality which was overt to her family and the non NHS psychiatrist who was approached by the family. Comments of a personal nature were made to her: paraphrased as "you are so pretty why would you want to kill yourself", by a male member of the team in a clumsy attempt to cheer her up which she and her boyfriend who was present found offensive. Lack of proper assessment of suicidality for example: seeming to ignore her actions, and concerns passed by her brother who was caring for her and over reliance upon no active suicidality being expressed when directly asked. Even when she was at times so unwell that she would not talk or was incoherent there was no reassessment of risk. Issues with planned visits not taking place.

	A stated culture by senior staff of positive risk taking in relation to suicidality. When her family in desperation sought advice from other psychiatrists, one of whom made an extensive telephone assessment of Valeria, and passed on the concerns from these professionals to the treating team, these were seemingly ignored in that there was no reassessment of risk, no change in treatment and no admission considered, nor even proper recording in the medical record. Despite the seriousness of her initial assessment in A&E, her past history, her family history and the potential for her to have a diagnosis of bipolar disorder, she was never personally assessed by an NHS consultant psychiatrist in this final episode of illness. She was not treated in line with BNF guidelines. A finding of fact was made that had her family been able to take her home to Chile the death would likely have been avoided at this time due to the different approach to treatment there.
5	**Concerns of the Coroner:** 1. That the Trust has a culture of risk taking in relation to suicidality. 2. That the Trust staff need training in relation to assessment of suicide risk, how to engage with families and carers, not to use inappropriate personal comment to try and bolster the patient, how to provide support to families and carers, that risk needs to assessed during the present treatment episode in order to mitigate suicidality at that particular point in time and in record keeping and updating. 3. That where appropriate admission should be considered to diagnose, and treat the patient and manage risk of self-harm. 4. That patients should be treated in line with BNF guidance. 5. That patients should be assessed in person by a fully qualified psychiatrist early on and during a treatment phase of illness of this potential seriousness. 6. That the Trust staff should be trained to consider the views of other qualified psychiatrists with knowledge of a patient. 7. That treatment plans and specifically visiting schedules should not be deviated from, such that planned visits take place unless there is a clinical indication to do so. 8. That this case seriously calls into question the operational ethos of the care in the community approach in West London.
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. 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 : [redacted], her brother representing her family The CQC The West London Coroner. 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	**11th February 2021** **Professor Fiona J Wilcox** **HM Senior Coroner Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED** **Honorary Professor QMUL School of Medicine and Dentistry**