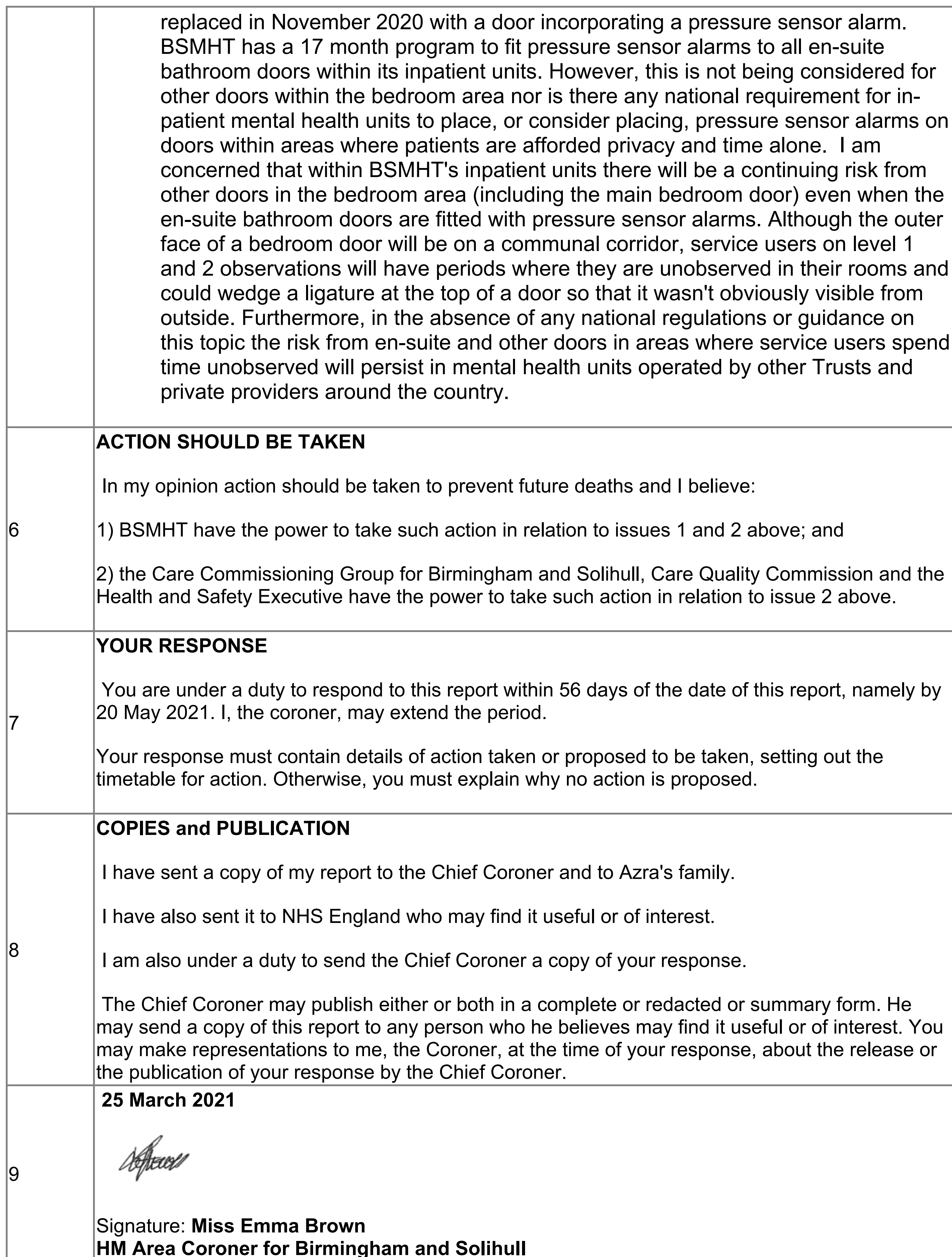
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Birmingham and Solihull Mental Health NHS Foundation Trust, the Care Commissioning Group for Birmingham and Solihull, the Care Quality Commission and the Health and Safety Executive.**
1	**CORONER** I am Emma Brown, Area Coroner for Birmingham and Solihull
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 15 May 2020 I commenced an investigation into the death of Azra Parveen HUSSAIN also known as Azra Parveen Sultan. The investigation concluded at the end of a 6 day inquest on the 22nd March 2021. The conclusion of the inquest was 'Suicide' and the jury also answered a set of questions which identify that they concluded: 1. On the 24th March 2020 there was a missed opportunity to commence ECT treatment and it is likely that Azra's death would have been prevented if she had undergone ECT. 2. On the 6th May 2020 there was a foreseeable risk that Azra would attempt suicide, that risk had not been adequately identified by those caring for her, adequate measures had not been taken to mitigate her risk and with adequate measures it is likely that Azra's death would have been prevented. 3. On the 6th May 2020 there was a foreseeable risk that the en-suite bathroom door would be used as a ligature point, adequate measures had not been taken to mitigate the risk and with adequate measures it is likely that Azra's death would have been prevented.
4	**CIRCUMSTANCES OF THE DEATH** On the 6th May 2020 Azra was found at approx 18:25 hours hanging from her en-suite bathroom door in room 14 on Ward 2 of Mary Seacole House having used her bedding to create a noose. Mary Seacole House is operated and staffed by Birmingham and Solihull Mental Health NHS Foundation Trust ('BSMHT'). Azra had been detained there on 26th December 2019 under section 2 of the Mental Health Act. She was on 15 minute observations and was last recorded as being seen at 18:09 when she was on her bed. An ambulance was called at 18:25 and arrived at 18:32. Staff had already cut Azra down and started CPR. She could not be resuscitated and was declared deceased at 19:38. Following a post mortem the medical cause of death was determined to be: **1a SUSPENSION BY LIGATURE AROUND THE NECK** **1b** **1c** **II**

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. – 1. On the 4th May 2020 Azra's mother and daughter had been in telephone contact with the nurse in charge on the ward expressing concerns that Azra had messaged them to say she had attempted suicide using shoelaces as a ligature. The nurse spoke to Azra who denied making a ligature, Azra's neck was examined and she had no marks from ligature use. The shoelaces from one pair of shoes were removed but other shoelaces, clothing and bedding were left in her possession as it was felt that Azra was not at an immediate risk. She was not believed to be at immediate risk because, whilst it was a feature of her mental state common to many patients that she would regularly talk about not wanting to live and requesting an overdose, there was no evidence that she had made an active suicide attempt and she had no history of suicide or self-harm attempts. The fact that she was now saying that she had attempted to make a ligature was a change in her presentation (her previous suicidal ideation had centred around requesting assistance to overdose), it was also of significance that she was saying one thing to her family and something different to a clinician. BSMHT accepted that the information was significant and therefore there ought to have been consideration of it by her treating team with a review of her risk and observation levels. However, no record at all was made of the family's concerns and the account given by Azra. Her risk screen was not updated, an incident report was not raised, and the information was not included in handover to the next shift or at the next MDT on the 6th May. Therefore, it was not considered at an MDT meeting on the 6th May 2020. Due to the COVID19 pandemic Azra's family could not attend that meeting and raise their concerns directly. Microsoft Teams was used by some clinicians to attend the MDT on the 6th May but was not made available to Azra's family nor was a telephone number to dial into the meeting. BSMHT has put in a system for a form to be completed in advance of an MDT which requires the family's input to be sought, placed on the form and considered in the MDT. It is my concern that this is equivalent to the family being included in the meeting (prior to COVID families were invited to attend MDTs): there is the potential that information will not be recorded accurately or will not be understood in written form, it also doesn't afford family the opportunity to hear the plan arising from the meeting and provide their views. There is no reason why attendance by a remote platform or telephone line at the meeting itself cannot be offered to family for all MDTs. 2. BSMHT had risk assessed ward 2 for ligature points, including the en-suite bathrooms, in November 2019. The en-suite bathroom doors were given the highest risk score possible on an acute ward, but no corrective action was identified to remove or mitigate the risk: the risk assessment relied on clinical assessment and observation of the service user to mitigate the risk. Evidence was given at the inquest that pressure sensor alarms have been available in the UK from numerous manufacturers for 10 years, BSMHT had been investigating and testing different pressure sensor alarms for en-suite bathroom doors for approximately 2 years before Azra's death. BSMHT has now identified an appropriate pressure sensor for en-suite bathroom doors and the en-suite bathroom door of room 14 on ward 2 was



	replaced in November 2020 with a door incorporating a pressure sensor alarm. BSMHT has a 17 month program to fit pressure sensor alarms to all en-suite bathroom doors within its inpatient units. However, this is not being considered for other doors within the bedroom area nor is there any national requirement for in-patient mental health units to place, or consider placing, pressure sensor alarms on doors within areas where patients are afforded privacy and time alone. I am concerned that within BSMHT's inpatient units there will be a continuing risk from other doors in the bedroom area (including the main bedroom door) even when the en-suite bathroom doors are fitted with pressure sensor alarms. Although the outer face of a bedroom door will be on a communal corridor, service users on level 1 and 2 observations will have periods where they are unobserved in their rooms and could wedge a ligature at the top of a door so that it wasn't obviously visible from outside. Furthermore, in the absence of any national regulations or guidance on this topic the risk from en-suite and other doors in areas where service users spend time unobserved will persist in mental health units operated by other Trusts and private providers around the country.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe: 1) BSMHT have the power to take such action in relation to issues 1 and 2 above; and 2) the Care Commissioning Group for Birmingham and Solihull, Care Quality Commission and the Health and Safety Executive have the power to take such action in relation to issue 2 above.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 20 May 2021. 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 Azra's family. I have also sent it to NHS England 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.
9	**25 March 2021** Signature: **Miss Emma Brown** **HM Area Coroner for Birmingham and Solihull**