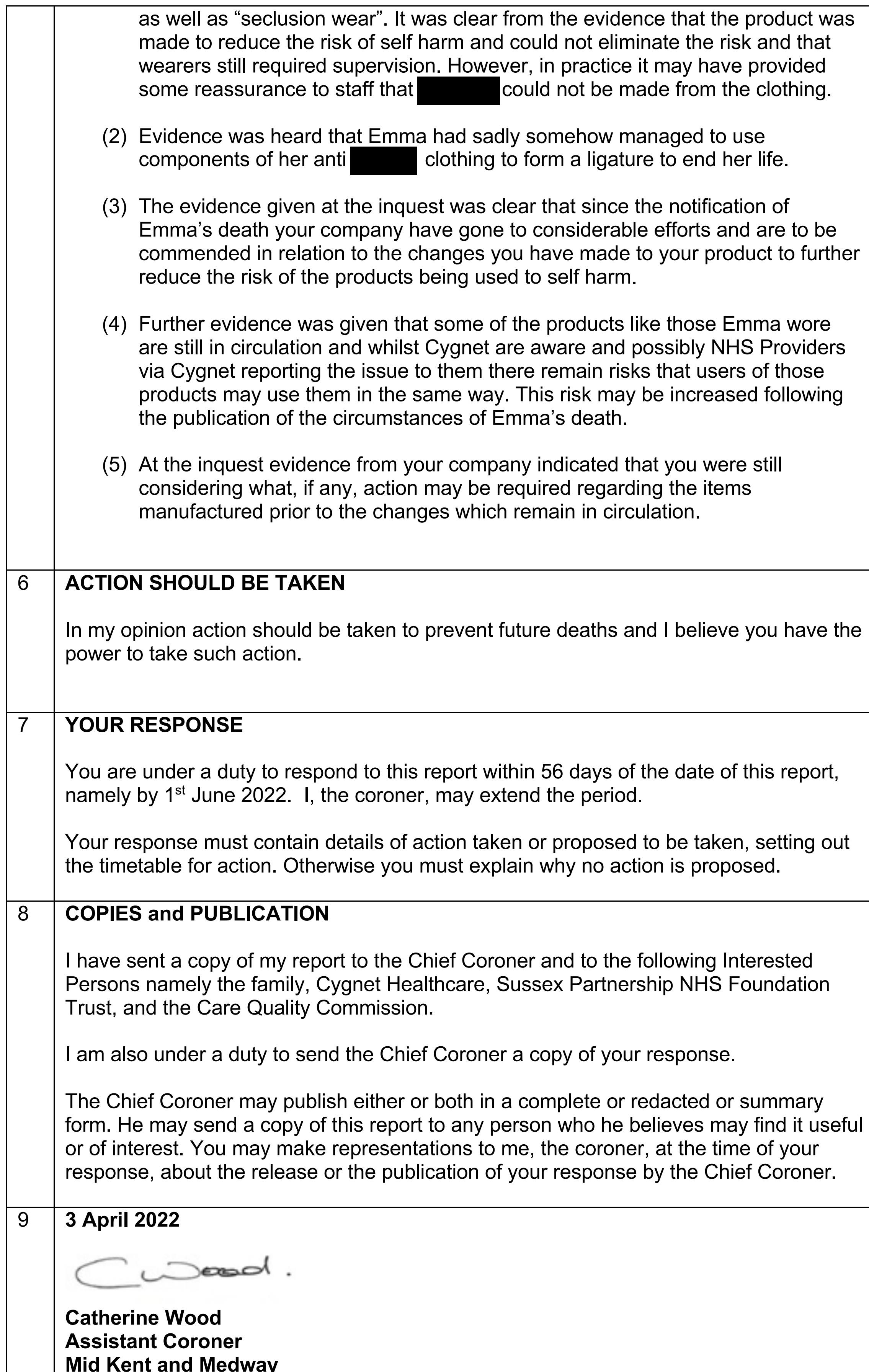
REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Interweave**
1	**CORONER** I am Catherine Wood, assistant coroner, for the coroner area of Mid Kent and Medway.
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 30th April 2021 an inquest was opened into the death of Emma Pring. At the inquest, which was heard with a jury and lasted seven days we heard from many of those involved in Emma's short life. The jury concluded on 18th March 2022 with a narrative conclusion "Emma Pring died from asphyxiation caused by self application of a [redacted]."
4	**CIRCUMSTANCES OF THE DEATH** (1) Emma Pring was diagnosed as suffering from Emotionally Unstable Personality Disorder and Post Traumatic Stress Disorder following two incidences of rape in her late teens. Her mental health was such that she made several serious attempts to end her life and she had several hospital admissions both voluntary, and at times compulsory under the Mental Health Act. (2) She was admitted to Cygnet hospital, Maidstone under section 3 of the Mental Health Act to undergo treatment including Cognitive Behavioural and Dialectical Behavioural therapies. The latter had recently commenced and she had undergone the first imaginal exposure therapy when her health deteriorated and she used [redacted] on the ward and was expressing wishes to self harm and end her life. She was placed on increased observations from every 30 to every 15 minutes and objects she could use to harm herself removed from her room and she was given "anti-[redacted] clothing" to wear. (3) She was not placed on one to one observation and somehow managed to make a [redacted] from the specialist clothing she had been wearing.
5	**<u>CORONER'S CONCERNS</u>** 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) Evidence given at the inquest revealed that Emma was wearing items of clothing manufactured by your company which are made in such a way as to reduce the risk of using the clothing to self harm. The evidence heard that the clothing was commonly referred to as "anti[redacted] clothing", or "safety clothing"



	as well as “seclusion wear”. It was clear from the evidence that the product was made to reduce the risk of self harm and could not eliminate the risk and that wearers still required supervision. However, in practice it may have provided some reassurance to staff that [redacted] could not be made from the clothing. (2) Evidence was heard that Emma had sadly somehow managed to use components of her anti [redacted] clothing to form a ligature to end her life. (3) The evidence given at the inquest was clear that since the notification of Emma’s death your company have gone to considerable efforts and are to be commended in relation to the changes you have made to your product to further reduce the risk of the products being used to self harm. (4) Further evidence was given that some of the products like those Emma wore are still in circulation and whilst Cygnet are aware and possibly NHS Providers via Cygnet reporting the issue to them there remain risks that users of those products may use them in the same way. This risk may be increased following the publication of the circumstances of Emma’s death. (5) At the inquest evidence from your company indicated that you were still considering what, if any, action may be required regarding the items manufactured prior to the changes which remain in circulation.
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 1st June 2022. 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 namely the family, Cygnet Healthcare, Sussex Partnership NHS Foundation Trust, and the Care Quality Commission. 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	**3 April 2022** C Wood. **Catherine Wood** **Assistant Coroner** **Mid Kent and Medway**