REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Gillian KEEGAN, Minister of State for Care and Mental Health with lead on suicide prevention** **2. CEO, North Yorkshire Clinical Commissioning Group** **3. CEO, Tees Esk and Wear Valleys NHS Foundation Trust ("TEWV")** **4. NHS England and NHS Improvement**
1	**CORONER** I am John Nigel BROADBRIDGE assistant coroner, for the coroner area of North Yorkshire and York including North Yorkshire Western District
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 2 September 2020 an investigation commenced into the death of Zoe Emma ZAREMBA ("Zoe") aged 25 years at her death. The investigation concluded at the end of the four day inquest on 14 April 2022. The Narrative conclusion was that: The deceased died because of suicide. Her death was contributed to by the actions and inactions of the mental health clinicians entrusted to keep her safe within a care system that was underdeveloped to manage an autistic individual with complex needs
4	**CIRCUMSTANCES OF THE DEATH** Zoe, who had a history of repeated self-harm and repeated attempts on her own life, should have received mental health care from community mental health services as well as inpatient care. She withdrew from engagement with those services because she did not trust those entrusted to keep her safe, in part because of clinicians' failure to understand her autistic condition and their reliance on an unsubstantiated attribution of a mental disorder instead. In her increased vulnerability and after discharge from inpatient detention on 20 May 2020 she received very limited support. On 21 June 2020 she was found unresponsive, despite searches, hidden by undergrowth on land adjacent to A684 (Bedale by-pass) having ingested an unknown quantity of [redacted] earlier at her home in the night of 13-14 June 2020 when she went missing from there. Her death was recognised where she was found at 16.40 hours that same afternoon, established as from the effects of that ingestion. .
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 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. –

The evidence indicated:
1 Zoe was diagnosed at age 16 years as being autistic by CAMHS with a designation of Asperger's Syndrome. Her medical records recorded that.

2 In or about 2016 she was wrongly attributed by the Mental Health Service, TEWV, clinicians - who knew of her autism -as undergoing Emotionally Unstable Personality Disorder ("EUPD").

3 That attribution was not formally diagnosed, and not discussed with Zoe who found out by chance when looking at her records. She continued to be regarded and treated as if she was experiencing that condition and clinicians would not adapt to her distress caused by that attribution. There was inertia and excessive delay (to May 2020) in removing reference to EUPD which had been discounted in October 2018 all of which added to her distress. These actions and inactions destroyed her relationship with community mental health clinicians and she did not trust them enough to try to restore any effective care relationship.

4 She suffered repeated trauma derived from her autistic condition revisiting the causes of her distress which she re-experienced time and again with 'film reel' recollection. That trauma was again not understood.

5 In short, her autism (and thus risk assessment) was misunderstood by the clinicians tasked to keep her safe.

6 TEWV's provision for cares of autistic conditions were underdeveloped, reflecting national want of provision, to include:-

A no multidisciplinary clinical assessment and formulation addressed her autism;

B no reasonable adjustments were then made in terms of her sensory and environmental needs in any timely fashion, or at all;

C no person centred (thus autism centred) holistic plan was developed to work in partnership with Zoe that took account of her autism, and her gender. As the evidence revealed one "cannot uncouple autism and other psychological/psychiatric experiences". Instead, she withdrew from engagement with TEWV community health clinicians.

D there was no local provision within TEWV for specialist autism assessment and adapted psychological therapy. Commissioned providers of these essential cares were outwith TEWV, requiring specific Funding Request (which was granted) for a course of assessment and therapy. Those providers did not offer statutory acute mental health services support, including out of hours/crisis support. TEWV did not provide what the commissioned providers were supplying. There was a want of effective communications between these 'teams' not least as patient data was not accessible by one to the others electronic records (patient consent permitting) and the fact of disengagement. There was a sense of 'silo' working, militating against partnership working, that encouraged unfavourably the undesirable "uncoupling" of experiences;

E statistical evidence indicated that autistic individuals are more at risk of suicide than those with no neurodevelopmental condition, and females at greater risk that their male counterparts;

	F there was a clinical (but not measured) experience that more patients were presenting to the statutory service with autistic conditions and, it follows, more patients would be at risk of suicide; G from 2016 to her death, Zoe was detained under ss 2/3 MHA 1983 17 times and presented to A and E around 37 times with evident self harm and apparent attempts on her life. She repeated high risk behaviours. She had no Care Co-ordinator nor effective Care Plan (which ought to have been in place) because she had not engaged with TEWV community services; H Zoe lurched form crisis to crisis remaining at high risk to her own safety; she died because she could no longer cope with the sense of injustice caused by others that overwhelmed her thinking. She felt she was not being listened to by community mental health services. Her therapy from outside providers - which was proving helpful to her - was disrupted by COVID-19 limitations on face to face consultations; Both locally, including regional, but also nationally the evidence revealed a number of serious issues that require urgent and immediate action to support autistic people well, not just from a sensory and environmental basis (which TEWV have started to improve albeit from a low baseline according to the evidence received). Urgent solutions are required to prevent future deaths of autistic patients especially with mental health needs.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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, namely by 21 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 : [redacted], Mother of Zoe 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 April 2022** **SIGNED BY** JN Broadbridge