VERONICA HAMILTON-DEELEY DL,
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Her Majesty's Senior Coroner
for the City of Brighton & Hove

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CORONERS SOCIETY OF ENGLAND AND WALES

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	THIS REPORT IS BEING SENT TO: 1. **Ms. [redacted] - Chief Executive, Sussex Partnership Foundation NHS Trust** 2. **Mrs. [redacted] – Head of Legal Services, Sussex Partnership Foundation NHS Trust** 3. **Mr. [redacted] – Chief Executive, Brighton & Hove City Council**
1	**CORONER** I am **Catharine PALMER,** Assistant Coroner, for the City of Brighton and Hove
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 **30th March 2020**, I commenced an investigation into the death of **Elena WELLS aged 31 years**. The investigation concluded at the end of the inquest on **9th November 2020**.The conclusion of the inquest was a **NARRATIVE CONCLUSION:-** **Elena Wells who had a history of mental health issues died from the effects of placing a tight ligature around her neck in circumstances where she was alone in her home, waiting for the ambulance to take her to hospital for a necessary admission regarding her mental health. The ambulance was delayed and other health professionals were waiting for its arrival to be with her. She appears to have read a phone message at 14.15 on 19th March 2020 but had failed to answer a slightly earlier call from her lead practitioner which caused concern. At approximately the same time as she read the WhatsApp message steps were being taken to get into her property which took a further 20 minutes. She was found with the ligature around her neck in the bedroom. Emergency services were called and resuscitation was attempted by those at the scene but she was not able to be revived. On balance of probabilities, at**

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	the time she knew people were at the door she took the steps to tie the ligature and end her life. **The medical cause of death was:-** **1a) Hanging** **b) ---** **c) ---** **11. Bipolar affective disorder**
4	**CIRCUMSTANCES OF THE DEATH** **Ms Wells returned to the UK in 2019. She had negative experiences with mental health treatment abroad which affected her trust of authorities on her return. In December 2019 when her mental health declined further she was referred to her local Mental Health Trust (the Trust). Seen twice in January it was agreed that she needed intervention from the Crisis Team. After 4 weeks she was transferred back to her Lead Practitioner (LP). In March the new Covid-19 restrictions negatively affected Miss Wells, and she became reluctant to take medication and was practising tying ligatures. Her LP recognised further decline. A Mental Health Act Assessment was quickly arranged on 18th March 2020 with two Doctors from the Trust and an Approved Mental Health Practitioner (AMP) from the Local Authority. An urgent informal admission rather than under Section was deemed necessary- she agreed. A local bed was not immediately available. She was deemed safe to remain at home until a bed was found on the basis that protective factors of (amongst others) her dog and flatmate were there. Advice included checking she had Crisis Team numbers and to attend A & E if necessary but there was nothing else in place to support her overnight to the following morning until a bed was found. The AMP was to find a bed however; one was not available until nearly lunch time 19th March 2020. During the night she deteriorated. Her flatmate supported her and contacted the LP the following morning expressing concerns; she then had to leave for work. Miss Wells had one lengthy phone call with her LP but she was not visited by any health professionals, she was alone in the property after her dog went to a sitter. Her LP and the AMP communicated together but evidence suggested that there was confusion over who held overall responsibility for her care. The LP sought advice from senior practitioners who said she only needed to go to her when the ambulance arrived. The ambulance was delayed. Evidence showed Miss Wells read a WhatsApp message at 14.15 but had not answered the phone to her LP at 14.04. Concerns were raised and the AMP attended her property at approximately 14.30 but could not gain access. It was a further 20 minutes before access could be gained and she was discovered with a ligature around her neck attached to her bed. She could not be revived.**
5	**CORONER'S CONCERNS**

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	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. **Both the Local Authority and the Trust were involved in the care of Miss Wells for the last 24 hours of her life. Evidence showed that there was a grey area in respect of responsibility for her care, at this time. There was no clear guidance as to who held overall responsibility for her care and there was no clear policy of how the two organisations should work together in these kinds of situations. It is requested that the Local Authority and the Trust consider how to improve communication and clearly define responsibility between the two organisations which could improve the safety of patients with serious mental health difficulties who were waiting for urgent admission to a mental health unit.** 2. **In this case a clinical decision was made to leave Miss Wells at home until a bed was found with Miss Wells, who was already ill enough to need urgent admission, having to inform the services if she declined further. No provision was made for Miss Wells to be reviewed out of hours, overnight and into the early morning by, for example the Crisis Team, and no advice offered on the existence of a place of safety at the local Mental Health Hospital. Evidence showed that professionals can contact the Crisis Team in these circumstances but that is not done as a routine and patients appear to be left to make important decisions for themselves in circumstances where their declining mental health may prohibit them from doing so. It is requested that the Trust consider ways of providing extra support and supervision to those patients who are waiting for an urgent admission, particularly those who may be left alone at home for any period until a bed is found.**
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

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	report, namely by **10th February 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 the following Interested Persons:- 1. [redacted] Wells - Mother 2. [redacted] Wells – Father I have also sent it to:- 1. Secretary of State for Health, Department of Health 2. [redacted], Chief Executive, NHS England 3. [redacted], Chief Executive, CQC 4. Dr [redacted], Brighton and Hove CCG 5. Mr. [redacted] – Head of Quality SPFT 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	**Date: 23rd November 2020 SIGNED BY:** [signature] **Assistant Coroner Brighton and Hove**

CORONERS & JUSTICE ACT 2009

Action to prevent other deaths

Schedule 5

PARA 7(1) Where ----

(a) a senior coroner has been conducting an investigation under this Part into a person's death,

(b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future and

(c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have power to take such action.

(2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it.

(3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner.

PART 7
Action to prevent other deaths

Report on action to prevent other deaths

28.—(1) This regulation applies where a coroner is under a duty under paragraph 7(1) of Schedule 5 to make a report to prevent other deaths.

(2) In this regulation, a reference to "a report" means a report to prevent other deaths made by the coroner.

(3) A report may not be made until the coroner has considered all the documents, evidence and information that in the opinion of the coroner are relevant to the investigation.

(4) The coroner—

(a) must send a copy of the report to the Chief Coroner and every interested person who in the coroner's opinion should receive it;

(b) must send a copy of the report to the appropriate Local Safeguarding Children Board (which has the same meaning as in regulation 24(3)) where the coroner believes the deceased was under the age of 18; and

(c) may send a copy of the report to any other person who the coroner believes may find it useful or of interest.

(5) On receipt of a report the Chief Coroner may—

(a) publish a copy of the report, or a summary of it, in such manner as the Chief Coroner thinks fit; and

(b) send a copy of the report to any person who the Chief Coroner believes may find it useful or of interest.

Response to a report on action to prevent other deaths

29.—(1) This regulation applies where a person is under a duty to give a response to a report to prevent other deaths made in accordance with paragraph 7(1) of Schedule 5.

(2) In this regulation, a reference to "a report" means a report to prevent other deaths made by the coroner.

(3) The response to a report must contain—

(a) details of any action that has been taken or which it is proposed will be taken by the person giving the response or any other person whether in response to the report or otherwise and set out a timetable of the action taken or proposed to be taken; or

(b) an explanation as to why no action is proposed.

(4) The response must be provided to the coroner who made the report within 56 days of the date on which the report is sent.

(5) The coroner who made the report may extend the period referred to in paragraph (4) (even if an application for extension is made after the time for compliance has expired)

(6) On receipt of a response to a report the coroner—

(a) must send a copy of the response to the report to the Chief Coroner;

(b) must send a copy to any interested persons who in the coroner's opinion should receive it; and

(c) may send a copy of the response to any other person who the coroner believes may find it useful or of interest.

(7) On receipt of a copy under paragraph (6)(a) the Chief Coroner may—

(a) publish a copy of the response, or a summary of it, in such manner as the Chief Coroner thinks fit; and

(b) send a copy of the response to any person who the Chief Coroner believes may find it useful or of interest (other than a person who has been sent a copy of the response under paragraph (6)(b) or (c)).

(8) A person giving a response to a report may make written representations to the coroner about—

(a) the release of the response; or

(b) the publication of the response.

(9) Representations under paragraph (8) must be made to the coroner no later than the time when the response to the report to prevent other deaths is provided to the coroner under paragraph (4).

(10) The coroner must pass any representations made under paragraph (8) to the Chief Coroner who may then consider those representations and decide whether there should be any restrictions on the release or publication of the response.