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.** Rt Hon Steve Barclay MP, Secretary of State for Health and Social Care **2.** [redacted], President of the Association of British Neurologists **3.** [redacted] President of the Royal College of Psychiatrists **4.** [redacted], Chief Constable of Dorset Police **5.** [redacted], Acting Chief Executive of Dorset Healthcare University NHS Foundation Trust **6.** [redacted], Chief Executive of University Hospitals Dorset NHS Foundation Trust **7.** [redacted], Chair of NHS Dorset **8.** [redacted], Chief Executive of Dorset County Council **9.** [redacted] Chief Executive of BCP Council **10** [redacted], Chief Executive Officer of the College of Policing
1	**CORONER** I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset
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 22nd November 2017, an investigation was commenced into the death of Gaia Kima Pope-Sutherland, born on the 2nd July 1998. The investigation concluded at the end of the Inquest before a jury on the 15th July 2022. The Medical Cause of Death was: 1a Hypothermia The conclusion of the jury was a narrative conclusion that Gaia Kima Pope-Sutherland probably passed away between 15.59pm on 7th November 2017 and 10.00am on 8th November 2017, from Hypothermia. Gaia's death was probably caused by her Mental Health and her Mental State on 7th November 2017.

4	**CIRCUMSTANCES OF THE DEATH** Gaia Kima Pope-Sutherland was diagnosed with epilepsy in 2013 which was described as complex, severe and unique. At the time of her death she was awaiting decisions regarding surgical intervention. She was diagnosed with Post Traumatic Stress Disorder in December 2016 after she disclosed a rape allegation in December 2015. On the 21st October 2017 she was taken to Poole Hospital, Poole where she underwent an assessment under the Mental Health Act 1983. She was discharged back to the care of her GP. On the 2nd November she received indecent images via social media and reported this to Dorset Police. On the 7th November 2017 Gaia left her aunt's address on [redacted] at around 15.30 hours in a psychotic state. She was last seen on CCTV at 15.59 hours on [redacted]. Following an extensive multi agency search she was found deceased on the 18th November 2017 in undergrowth on the clifftop [redacted]
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. During the inquest, evidence was heard that: i. There is a complex relationship between epilepsy and mental health. It is essential for there to be good communication between those working in the 2 specialities when a patient is under the care of the 2 disciplines. ii. [redacted], a Professor in Neurology at the National Hospital for Neurology and Neurosurgery, and at the University College Hospital London NHS Foundation Trust, who treats patients from across the country, confirmed that there is generally a lack of communication throughout the NHS between community psychiatric teams and neurology teams, across England and Wales. When asked if he felt that better communication would probably lead to better care and therefore prevent future deaths, he replied, "absolutely". He explained that in the past, General Practice would act as a very useful hub for communication, but in his opinion, they do not now have the time or resources to manage the communication. He explained that people with epilepsy are 4 times more likely to die by suicide and that the one thing that could be done to improve and protect lives, is better communication across the 2 disciplines. iii. [redacted], a specialist nurse in epilepsy care in Dorset,

explained that because of the number of patients she sees, she does not routinely look through everybody's records as she does not have the time. She explained that there are 10,000 adults in Dorset with active epilepsy and that she is 1 of 2 epilepsy nurses that cover the epilepsy nursing care across Dorset. She did not feel that there are sufficient resources to do all the things that need to be done in treating the patients. Evidence was further given that there are lengthy waiting lists for pre surgery investigations for epilepsy. Evidence was given that epilepsy services are therefore under resourced.

iv. Epilepsy is a life-threatening condition. Police Officers provided evidence that they did not have training on epilepsy and mental health conditions such as post ictal psychosis, PTSD and those who have experienced sexual trauma. It is important for Police Officers dealing with people with complex needs, such as epilepsy, psychosis, PTSD and sexual trauma, to know how to deal with such individuals. Whilst it is acknowledged that Police Officers are not medically trained and should rely on medical professionals for care, having a basic understanding through training, of the behaviour of those suffering with these significant illnesses, and the impact such issues may have upon them, may assist Police Officers when dealing with, or searching for, missing persons, and therefore prevent future deaths.

v. A considerable amount of evidence was heard during the Inquest around the policies and procedures in place within Dorset Police regarding concern for welfare reports, reports of missing persons and the call handling, grading and deployment of resources. It was clear from the evidence that some parts of these policies remain ambiguous or confusing. For example, in the Call Handling, Grading and Deployment Policy, there is no specific paragraph that explains that the Force Incident Manager should be notified of a high risk missing person and also wording such as *"High Risk Missing Person – immediate threat to life"* can be misleading. These ambiguities could lead to wrongful application of the policy, which could lead to a future death. There is also reference to a Public Protection Notice (PPN), only being submitted once a missing person has been found and this defeats the objective of multi-agency working during the missing person search, as a PPN could yield further information from other agencies to assist in the search.

vi. As well as the policies appearing to be ambiguous in places, there was evidence of confusion around interpretation of the policies and lack of knowledge of the policies within Dorset Police, especially the missing person policy.

vii. During the missing person investigation by Dorset Police, and after Gaia was found deceased, there was evidence of poor record keeping, including records not being made, or when they were made not being sufficiently detailed and records being

retrospectively made and changed without the records being clearly marked that the entries were retrospective. Evidence was given that Police Officers learn about record keeping during their initial Police training, however, there is no evidence of further record keeping training within Dorset Police. The quality of records may impact, amongst other things, upon locating a missing person which gives rise to a risk of a future death.

viii. In respect of record keeping, there have been changes made during the Inquest in the way that the Police Search Advisor (PolSA) log in Dorset Police is created, held and updated on the computer system, Niche. Evidence was given that the Lost Person Search Manager (LPSM) log has not been amended in a same way and is still being stored by Dorset Police in a similar way to which the PolSA log was being stored at the time of Gaia's death. This opens up the opportunity to amend the log, which can lead to the adding or deleting of information and could lead to records being misinterpreted. This poses a risk to the management of missing person investigations and potentially reduces the chances of locating a person alive.

ix. Evidence was provided that Gaia was the victim of sexual harassment whilst an inpatient under the care of the mental health teams. Evidence was provided that such conduct can trigger a deterioration in mental health. There is no policy currently in place within Dorset Healthcare University NHS Foundation Trust (DHUFT) that deals with how staff working within the Trust should handle incidents of sexual harassment or assault. If this conduct is not dealt with appropriately this could lead to a future death.

x. Evidence was given that there was a lack of communication between Gaia's family and those caring for Gaia at DHUFT, despite attempts for the family to liaise with them. Although some policies may touch upon communication, there is no specific policy in place regarding communication with family members who would be able to inform those treating the person, about the patient and their needs. Evidence was given that DHUFT adopt an approach called Think Family, but again there is no policy or guidance in place around what this concept is or how it should work in practice.

xi. Evidence was given by Mental Health professionals during the Inquest, that when there are a lot of records, you could not be expected to look through all the records due to the time that it would take. The records system used by DHUFT is called RiO and the system does have a function of flagging or recording information on an alert. This enables key information to be flagged for anyone looking at the record. It does not appear from the evidence that this was used in respect of Gaia's records and at the moment there is no guidance document as to how to flag information on RiO, or training in place as to when and how key

information should be flagged so that it will be seen by all those involved in the person's care.

xii. There are policies in place in DHUFT regarding access to Community Mental Health care, however there was some ambiguity and inconsistency during the evidence regarding the content of the policy and the understanding and application of it.

xiii. Evidence was given that when Gaia was discharged from Poole Hospital on the 22nd October 2017, following the Mental Health Act assessment, a discharge summary was provided to her GP from Poole hospital. The Mental Health Act assessment was carried out by 3 individuals, 2 psychiatric doctors from the Mental Health Trust and an Approved Mental Health Professional from the local authority. The psychiatric doctors undertaking the Mental Health Act assessment did not send any information back to the GP, nor did the AMHP. The information contained within the discharge summary from the medical team to the GP was not correct and did not accurately reflect what had happened with Gaia. DHUFT now have in place a Standard Operating Procedure for the flow of information following Mental Health Act assessments that came into force on 29.5.22, during the Inquest. Within this document, it refers to the fact that the acute hospital and the AMHP will report back to the GP and the DHUFT clinician will complete a written record and place this on the RiO records, and will pass information to the medical doctor which can be recorded on the discharge summary. There is therefore no direct line of communication to provide information from the Mental Health teams to the GPs to be acted upon by the GP or passed to other teams such as neurology. This creates an opportunity for key information gaps in a person's care and could lead to a future death. I believe that the best placed person to report back to the GP, would be the person leading the assessment. During the Inquest, evidence was given that in Gaia's care this was [redacted] who at the time was a ST5 trainee working with DHUFT.

xiv. Evidence was also given that within the Standard Operating Procedure for the flow of information following Mental Health Act assessments, the AMHP will contact the patient's GP via telephone or email, although there is no timeframe for this stipulated in the document, and a follow up email will be sent with a covering letter and a copy of the AMHP assessment report within 7 days of the completion of the assessment. This appears to be a long period of time, and I note that the original suggestion in the Standard Operating Procedure was 72 hours. Any delay could be significant with someone who has presented in such a condition that they require a Mental Health Act assessment.

2. I have concerns with regard to the following:

   i. As per paragraphs 1(i-iii) above, there could be future deaths locally and across the country due to the lack of resourcing of epilepsy services. I request consideration is given to a review of the nursing resources in epilepsy care locally in Dorset Epilepsy Service, and generally nationally across England and Wales.

   ii. Further I am concerned that there could be future deaths as a result of the lack of communication between neurology and psychiatric teams and request that there is consideration as to how to ensure effective lines of communication between the 2 disciplines.

   iii. As per paragraph 1(iv) above, there could be future deaths due to the lack of knowledge Police Officers in England and Wales have around life threatening illnesses, such as epilepsy and mental health illness, and I request that consideration is given by the College of Policing to providing national training to all staff across all police forces, on illnesses such as epilepsy and mental health illness, and the impact they have on individuals and their behaviour. I also request consideration to be given to these topics forming part of the syllabus for the College of Policing induction training for Police Officers.

   iv. As per paragraphs 1(v-vi) above, there could be future deaths that occur as a result of current Dorset Police policies around concern for welfare reports, missing persons reports, and the call handling, grading and deployment of resources and I request that consideration is given to a thorough review of these policies to reduce ambiguity and prevent future deaths. I would further request that consideration is given to providing a comprehensive training package to all Police Officers and control room staff within Dorset Police, around the missing persons policy, concern for welfare policy, and for control room staff only, the call handling, grading and deployment policy.

   v. As per paragraphs 1(vii-viii) above, there is currently a risk that Dorset Police records are not created, completed or stored in an appropriate way. This could result in a lack of detail, or incorrect information being recorded and relied upon, which could lead to a future death. I therefore request that consideration is given to reviewing how all Dorset Police records are held, to ensure integrity of the information, and that consideration is given to providing a training session on record keeping for all Dorset Police staff, across all areas of the Force.

   vi. As per paragraph 1(ix) above, the occurrence of sexual harassment or assault whilst an inpatient at one of DHUFT's inpatient units could have a detrimental effect on a person's mental health which could have fatal consequences. I request that consideration is given to a policy being put into place to

	provide guidance to staff as to how to deal with this situation. vii. As per paragraph 1(x) above, there is no specific policy in place within DHUFT around contact with the family or dealing with the Think Family approach. A lack of contact with family members, who know the patient best, could lead to information gaps, which could lead to future deaths. I request that consideration is given to a policy being created around contact both to, and from, a patient's family. viii. As per paragraph 1(xi) above, information could be lost on lengthy RiO records held by DHUFT if there is a significant number of records, and I therefore request that consideration is given to a guidance document dealing with how and what information should be flagged on RiO which could be provided to all staff at DHUFT. I would further request consideration is given to training staff how to record information, so it is flagged on the record. ix. As per paragraph 1(xii) above, I would request that consideration is given to providing training to all staff on the access to Community Mental Health services which could also cover the processes regarding discharge planning from the care of the mental health teams. x. As per paragraph 1(xiii) above, when a Mental Health Act assessment is undertaken, there is a possibility that information may not be fed back to the GP in the best way or in a timely manner, if it is not fed back by those from the Mental Health team, and I therefore request that consideration is given to the DHUFT representatives forwarding information, directly to the GP, rather than through the discharging team at the acute hospital. This may include their RiO record notes, or their assessment notes. xi. As per paragraph 1(xiv) above, in respect of the feeding back of information to the GP by the AMHP which is detailed at paragraph 2.10 of Standard Operating Procedure for the flow of information following Mental Health Act assessments, I would request that consideration is given by Dorset County Council, BCP Council and DHUFT to reducing this timeframe from 7 days to 72 hours. Although this is a decision for Dorset County Council and BCP Council, the document is a DHUFT document and so will require their consideration too.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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, 15th September 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: (1) Gaia's Maternal Family (2) [redacted] (3) Dorset County Council (4) Dorset Healthcare University NHS Foundation Trust. (5) Dorset Police (6) Dorset Search and Rescue (7) Her Majesty's Coastguard (8) Independent Office of Police Conduct (9) National Police Air Service (10) South West Ambulance Service NHS Foundation Trust (11) University College Hospital London NHS Foundation Trust (12) University Hospital Dorset NHS Foundation Trust (13) [redacted] (14) [redacted] 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	**Dated** **21st July 2022**	**Signed** **Rachael C Griffin**