REGULATION 28: REPORT TO PREVENT FUTURE DEATHS.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted] - Chief Executive Alternative Futures Group. (AFG) Lion Court Kings Drive Prescot Lancashire • [redacted] and [redacted] former Directors of Safety Matters Ltd (a company which has now been dissolved) • [redacted] and [redacted] of a new company Safety Matters (Legal) Limited, whose Registered office address is 5b South Preston Office Village, Cuerden Way, Bamber Bridge, Lancashire, United Kingdom, PR5 6BL. • [redacted] Medical Director GMMH NHS Trust Trust HQ, Bury New Road Prestwich Manchester M25 3BL Copied for interest to: • [redacted] - the deceased's mother • [redacted] - the deceased's father • [redacted] - the deceased's stepfather • The Care Quality Commission • Manchester Health and Care Commissioning
1	**CORONER** I am: Senior Coroner Nigel Meadows Senior Coroner for Manchester City Area HM Coroner's Court and Office Exchange Floor The Royal Exchange Building Cross Street Manchester

	M2 7EF
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 17th January 2019 I commenced an investigation into the death of Shona Christine Michaela Campbell. The investigation concluded on the 17th June 2022. The Conclusion of the inquest was**: ACCIDENT as part of a narrative Conclusion**
4	**CIRCUMSTANCES OF THE DEATH** Shona had suffered psychological trauma as a child and had been treated by mental health services since the age of about 8. By the age of 18 Shona had an established diagnosis of a severe emotionally unstable personality disorder (EUPD) together with emotional dysregulation and was at high risk of impulsive behaviour that could lead to serious injury or death. She had a long history of self-harming but cutting herself with sharp objects and had multiple scars on her body. Shona was transferred to Tesito House psychiatric unit ("Tesito") from an acute psychiatric unit on the 22nd January 2018. Tesito was operated by Alternative Futures Group ("AFG"). This is a not-for-profit Charitable organisation that operates several psychiatric units. Tesito was a 24 bed unit in Ardwick , Manchester to treat and support women with complex needs which opened in 2017 but only cared for 8 patients. Services were provided in partnership with Greater Manchester Mental Health Trust ("GMMH") Shona was a patient of GMMH and was detained under section 3 of the Mental Health Act. This meant she was suffering from a mental disorder of a nature or degree which made it appropriate for her to be detained in hospital in the interests of their own health and safety or the protection of others and that there was appropriate treatment available to her which could not be given unless she was detained in hospital. That remained her legal status. Her Responsible Clinician ("RC") was a GMMH Consultant Psychiatrist assisted by a locum junior Psychiatric doctor who worked on weekdays. Multidisciplinary team (MDT) meetings and ward rounds occurred frequently but sometimes were not attended by her named nurse and nor were the records of these kept appropriately updated and/or reviewed. At Tesito she was treated with antipsychotic medication, mood stabiliser drugs and antidepressants together with psychological therapies. Shona said that she heard voices of a persecutory and a derogatory/negative nature as well as having visual hallucinations. These were not assessed to be genuine psychotic symptoms but represented intrusive thoughts when she became distressed. However, even if they were not psychotic related auditory hallucinations, she could still act upon them. There were numerous incidents [redacted]

on repeated occasions particularly when she was emotionally distressed and/or when she acted impulsively. [redacted]. Whilst on section 17 leave from the unit she had absconded on more than one occasion and also took overdoses of paracetamol for which she required hospital treatment. During one of the hospital admissions she was able to cut her neck [redacted] she had kept from a previous home visit. Her mood and condition was very variable and she could change from being happy and stable to becoming distressed and self-harming extremely quickly. Sometimes she said that this arose out of frustration and that at other times because she wanted to kill herself.

The last formal risk written management plan was prepared on 16 October 2018 but was not regularly updated prior to her death. Her overall management was dealt with at MDT/ward rounds. After a period of Christmas home leave on 25 December 2018 she returned to the ward intoxicated and expressing suicidal ideas [redacted]. There were seven further incidents of her using ligatures between the 28th and 31st of December and ligature cutters had to be used to remove them. On the 31 December she described hearing voices telling her to end her own life. There were further incidents of headbanging and on the 1 January 2019 during another incident of head banging she threatened to hit a member of staff who had attempted to remove items from her room in order to ensure her safety given the risk of self-harm.

Shona's ability to repeatedly access forms of ligature was said to be a matter of concern but there was no clinical management plan formulated to address the risk that this posed and investigate how this was occurring.

[redacted] she was obviously cyanotic and suffering from asphyxia. Ligature cutters were used to remove the ligature. On the morning of 8 January, she was found to have ligatured again and resisted staff who try to remove it. She ligatured it again within an hour and then once more in the afternoon. At the MDT/ward round on 9 January her condition was noted to have improved and for the next couple of days she was stable but was still regarded as being at high risk of self-harm or suicide and was on 15-minute observations. The nursing staff had the discretion in the exercise of their clinical judgment to take such action as they thought were appropriate to protect her life.

During the early evening of 11 January, she was noted to be in happy and stable mood. At about 03:15 hours on 12 January she was found in the bathroom of her room with a ligature [redacted]. This was removed by the use of ligature cutters although Shona resisted attempts to do this. She declined PRN medication and was preoccupied by using her phone but did not appear to be distressed. The nurse in charge decided not to put her on one-to-one constant observations but on random nature for shorter periods of time. She also decided not to search her room. Although the nurse in charge had last worked shortly before Christmas, she was aware of Shona's general history of self-harming behaviour and that she had also read and was aware of the records relating to the incidents that happened at the end of December 2018 and also on the 1, 7 and 8 of January 2019. She was also aware that the use of ligatures by Shona could be fatal.

At about 04:23 hours she was found in her room just inside the door in a state of cardiac arrest with another ligature [redacted] Staff removed the ligature and began CPR was although a defibrillator was brought to her room it was not used but it was not explained why. About 10 minutes later paramedics arrived and took over the resuscitation. There was a return of spontaneous circulation, but it was not necessary for them to use their defibrillator.

	She was taken to the Manchester Royal infirmary where despite treatment her condition deteriorated, and she died on 14 February. She died as a consequence of asphyxiation due to ligature strangulation After Shona was found in a state of cardiac arrest on 12 January some staff made retrospective clinical records which began at 05:35 hours. A support worker recorded that another support worker had been told by Shona that she was planning to ligature during the night but no contemporaneous clinical records were made of this. Neither of them could specifically recall telling the nurse in charge. The nurse in charge countersigned this record and agreed that she must have read the clinical note. Further clinical records were made and timed at 06:00 hours by the nurse in charge and she made no reference to this issue. She subsequently made her manuscript statement and a police statement but did not make any reference about the support worker recording that Shona had told them that she was planning to ligature and that she was unaware of this. No record was made after Shona was found to have used to ligature at about 03.15 hours or that the nurse in charge asked her whether or not she had another ligature and Shona had denied doing so. Although there were meant to be four observations an hour performed there were missing observations and, on some occasions, other members of staff were asked to do the observations but that was not recorded. The nurse in charge was unaware of this. Consequently, the records were not complete or accurate. It was also established that the women on the unit would swap or acquire objects to harm themselves including ligatures and this was known by the staff. A company called “Safety Matters” was commissioned by AFG to undertake a serious incident investigation and produce a report examining the circumstances surrounding her care and treatment as well as the appropriateness of the service provided. In addition to identify any root causes or contributory factors and make recommendations to reduce the likelihood of re-occurrence. The author said in the report that he had undertaken many reviews of services, staffing models, suicides and homicides including root cause analysis. One of the authors agreed that it was not a full and thorough report because there were other documents and information, he would have liked to obtain but did not or did not think they were relevant. He was unaware that any members of staff had made manuscript witness statements shortly after the events. Nor did he ask for any staff member to prepare a statement during the course of his investigation. Although he was aware that there was a police as well as a coronial investigation he did not think it relevant to ask whether or not any evidence or witness statements could be disclosed to him. The report did not consider whether the observation records were accurate and if not why or how they were undertaken in practice. The investigation was concluded without knowing the pathological medical cause of death, but on the basis that Shona had died as a result of the use of ligature. The clinical and other staff involved were interviewed and written records of those interviews were kept but there was not a consistent method of ensuring that those interviewed agreed with the records or wished to amend and correct them. However, important issues were not investigated. The support workers were not asked about what was or what was not recorded in the clinical notes concerning Shona saying she was planning to ligature and whether or not they told anyone else and if so who and when and why no clinical records were made of it. The nurse in charge was not asked whether or not she was aware of this and, if so, what she did about it or her clinical rationale for her decisions. Nor was she asked why she had not made any reference to it in her own retrospective clinical records if she was unaware of this important clinical information. The nurse was recorded as saying that “Policy seems to be let people have ligatures to take responsibility even if they have to be cut off many times during the day.” This was not further investigated with AFG.

	The Care Quality Commission ("CQC") carried out an inspection of the Service on 6th and 7th March 2018 and published a report dated 24th July 2018. Having reviewed the records of all eight patients at the Service, the CQC found that not all patients had written risk assessments. Those risk assessments that were in place were poorly written and individual risks to the patients and others were not sufficiently mitigated. In five care records, although risk assessments were present, they were not comprehensive. Risk management plans lacked detail and, where a level of risk was identified for one patient, there was no evidence of review or updates of the assessment. Following incidents, risk management plans were not updated. At the time of the inspection the staffing establishment levels were below those identified for the Service. This resulted in 50% of the shifts being filled by bank and agency staff. The Service did not have a robust process for identifying the required staffing levels, but the staff received appropriate training. Overall, the service was rated as **Inadequate**. The CQC carried out a further inspection of the Service on 13th December 2018 and published a report dated 27th February 2019. Overall, they found that that there had been improvements in patient risk assessments and their review as well as care plans. Lessons learned from incidents were not always being shared with staff at the Service. Mandatory training had not been completed by all eligible staff. Only half the qualified nurses had completed intermediate life support training. Staff did not receive all the training required to perform their roles prior to working with individuals. Staff did not have access to specialist training to work with high-risk patients. Staffing levels did not ensure that patients had a consistent level of support and access to activities. Systems processes and standard operating procedures were not reliable or appropriate to keep people safe. Overall, the service was still rated as **Inadequate**. AFG submitted an application to the CQC to cancel the registration for Tesito House on the 21 February 2019 and CQC removed the location from being a registered service provider on the 28 February 2019.The unit was then closed. The CQC did not carry out an investigation themselves after Shona died because Tesito House had been de-registered and closed although they could have done because she was a detained mental health patient.
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. The lack of appropriate contemporaneous clinical record keeping by the nurse in charge as well as other nurses.

	2. The lack of appropriate contemporaneous clinical record keeping by the Support Workers. 3. Patient observations were not being completed as directed and accurate records were not being kept. 4. There was inadequate communication between the Nurse in Charge and Support Workers about important clinical information relating to self-harm as well as completion of observations and the records. 5. That patients could obtain ligatures and other objects that could be used for self-harm/suicide and/or used against other patients and staff members. 6. Regular training on all the applicable policies/procedures and use of an Automated Electronic Defibrillator. 7. Completion and updating of all care plans including risk assessments after MDT meetings/Ward rounds as well as an auditing process. 8. The need for appropriate clinical supervision of nurses and support workers. 9. The lack of a clear clinical assessment and plan to investigate and deal with repeated self-harm attempts that could result in serious injury or death as well as the repeated access to and use of ligatures. 10. The opportunities missed by the Safety Matters Ltd Serious Incident Investigation report process to obtain other relevant information and/or make additional enquiries which could affect the overall findings and recommendations for learning, improving practice and procedure as well as patient safety. This will also help improve other investigations that the authors of the report may do in the future.
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 the 5th 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 Interested Persons. I have also sent it to organisations 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: 1st July 2022** **Mr Nigel Meadows** HM Senior Coroner Manchester City Area **Signed:**