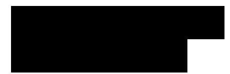
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Chief Exec of Cheshire Wirral Partnership NHS Foundation Trust**
1	**CORONER** I am David LEWIS, Assistant Coroner for the coroner area of Liverpool and Wirral
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 17 April 2018 an investigation was commenced into the death of Katharine Mary TYRER aged 44. The investigation concluded at the end of the inquest on 29 September 2022. The conclusion of the inquest was that: Suicide- Missed opportunities between the hours of 11.00am and 12.00 noon, an under estimation of the risk Katharine Mary Tyrer posed to herself. Compounded by inadequate risk assessment process and ward layout.
4	**CIRCUMSTANCES OF THE DEATH** On 3 April 2018 the Deceased ('Katharine') was transferred to the Lakefield Ward at Clatterbridge Hospital from Aintree Hospital, to which she had been admitted on 28 March 2018 after suffering multiple spinal fractures when she jumped from height into the River Mersey in an attempt to kill herself. She was a detained patient under Section 2 of the Mental Health Act. Katharine was well known to the clinical staff on the Lakefield Ward, having been admitted as both a detained patient and on a voluntary basis on a number of previous occasions, typically following impulsive episodes of self-harm or actions consistent with attempts to take her own life. It was known that these occurrences would often follow a 'trigger event', notably including disagreements with her husband. Her diagnosis at the time was emotionally unstable personality disorder, for which she was being treated appropriately, in line with national guidance. In the past she had been diagnosed as suffering from schizophrenia, but this was dropped as a secondary diagnosis in 2016. On 6 April 2018 Katharine was moved from a room on the main corridor of the Lakefield Ward to one tucked away, further from ward staff. On 11 April Katharine asked for her level of observations to be reduced. They were, from L2 to L1. Later the same day she reported feeling emotional and increasingly impulsive. On 12 April 2018 she left the ward at 10:07 to meet her husband outside. They argued and the meeting was cut short. He rang ward staff to inform them about what had happened and that she was returning. Katharine arrived back at 10:25 and, prompted by the call, a Clinical Support Worker visited Katherine's room and found her crying and upset. PRN medication was offered and accepted; and given at 10:40 by a nurse. Katharine was then left alone but shortly afterwards pressed her alarm bell to request assistance with her back brace. Four ward staff attended and helped, but had left again by 10:55. They had no concerns, despite Katharine reporting that she felt sickly. A different member of staff saw her on the hourly observation round at 11:00. Katharine was not seen again until 12:00, when a Trainee Nursing Assistant performing the hourly observation round found her unresponsive in her bathroom, with a ligature

	[redacted] Despite prompt CPR and 25 minutes of Advance Life Support she died at the scene. The Trust's RCA found that (inter alia) documentation around risk assessment and care planning fell short of expectations. A Trust witness explained that improvements have been made in those respects since Katharine's death. The court's independent expert considered the ward layout 'wholly inadequate'. The jury found that Katharine had committed suicide, but concluded that missed opportunities to affect the outcome between 11:00 and 12:00 on 12 April 2022, as well as an under-estimation of the risk Katharine posed to herself, had contributed more than minimally to her death, as had the ward layout and inadequate risk assessment.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) 1. The ward layout did not lend itself to easy observation of patients. The Court's expert considered it 'wholly inadequate'. The jury felt that this contributed more than minimally to Katharine's death. A number of rooms (including Katharine's room, 23) were remote from the nursing station and largely out of sight unless visited for a specific purpose. Whilst I am aware that some changes have been made since 2018, I am concerned that the current layout continues to place vulnerable patients, who might take their own lives, at risk. It is appreciated that the Trust might not be in a positon to create a ward which eliminates all of the layout issues. However, mitigation measures might be appropriate if the present facilities are to be used on an ongoing basis in an unmodified form. I am concerned that the limitations presented by the current layout may mean that staffing levels need to be adjusted to allow for greater levels of informal observation, oversight and monitoring. 2. The argument with her husband was a trigger event for Katharine. She was seen briefly by some ward staff between her return to the ward at around 10:25 and 11:00, but left completely unattended between 11:00-12:00. The jury felt that there was a missed opportunity at this time to affect the outcome and that the assessment of the risk that Katharine posed to herself had been inadequate. The evidence indicated that ward staff (seemingly regardless of their level of experience and seniority) who attend a patient in a situation like this are left to determine what (if any) action to take based upon their clinical judgement. In particular, it is left to the individual to decide whether escalation to a senior clinician would be appropriate and whether observations or monitoring (or even simply staying with the patient) should be increased for a period of time. I was told that it would not be unworkable in any scenario such as this (involving knowledge of a trigger event in the case of an impulsive patient with a known history of suicide attempts and self-harm) for there to be a procedure which called for an automatic review by the senior clinician on the ward at the time. However, that is not the current situation. I am concerned that, in the absence of a clear protocol, relatively junior staff (who may not be able to effect an adequate risk assessment) may not be equipped to determine how best to address the short-term risk.
6	**ACTION SHOULD BE TAKEN** In my opinion 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, namely by November 25, 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 **Chief Coroner (reg28)** I have also sent it to  who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 30/09/2022** David Lewis **David LEWIS** **Assistant Coroner for** **Liverpool and Wirral**