IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Sandra KIRK
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • [redacted], Chief Executive, NHS England and NHS Improvement, PO Box 16738, Redditch B97 9PT, England.contactus@nhs.net
1	**CORONER** Ms Anna Loxton, HM Assistant Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	**INVESTIGATION and INQUEST** The inquest into the death of **Sandra Kirk** was opened on 5th November 2021. It was resumed on 5th September and concluded on 15th September 2022 before a Jury. The Jury found the medical cause of death to be: 1a. Asphyxia due to ligature around her neck The jury returned a narrative conclusion, recording that Sandra had no mental health history until after she contracted Covid-19 in November 2020. Whilst she appeared to make a full physical recovery, she became increasingly preoccupied by the delusional belief that she had sustained a permanent degenerative brain disorder as a result of Covid, which was progressive and terminal. They recorded that as a result of this fixed belief, she attempted suicide on 23rd February 2021 with a carefully planned overdose and carbon monoxide poisoning, leading to a diagnosis of psychotic depression and

inpatient care until 5th March 2021, with Community Health Recovery Service follow up in the community.

On 15th May 2021 she attempted to end her life [redacted] She was admitted to Cygnet Hospital Woking ("Cygnet") under section 2 of the Mental Health Act on 17th May 2021. Whilst on section 17 escorted leave on 9th June 2021, she again attempted [redacted] resulting in her being detained under section 3 of the Mental Health Act; her leave being revoked; and observations increased to every 15 minutes before being returned to general hourly observations.

Sandra disclosed that she was non-compliant with medication to a friend, and this was reported to Cygnet staff on 27th July 2021 at an MDT meeting. A search of her bedroom was undertaken later that afternoon, following a similar disclosure via another patient that Sandra had reported non-compliance. During this search no medication was found. A [redacted] were found and removed from her bedroom, in accordance with Cygnet's Restricted/Prohibited Items policy, which identified such items as "not allowed because it would not be safe for them to be used in this environment". A Nurse who carried out the search gave evidence that she had noted [redacted] during the search, but these were not removed as Sandra was not deemed to be a specific risk of ligature.

On 30th July 2021 Sandra herself confirmed to a member of nursing staff that she had been spitting out her lithium medication.

On the morning of 2nd August 2021, Sandra's 57th birthday, she was recorded as being in the bathroom at 7.02am observations with the shower running. At 7.55am observation, she was found deceased on the bathroom floor [redacted]

The Jury recorded that "Sandra's high risk of suicide, in combination with the risk posed by ligatures to both other service users and Sandra herself, and the high percentage of in-hospital suicides which are undertaken through ligature use, mean that it is probable that the failure to remove the dress belt when it was brought in to Sandra on 6th of June contributed to her death. In addition, [redacted] was not removed when it was brought in and that it remained in the room following the search on 27th July 2021, the failure to remove it is also a probable contribution to her death. The risk of ligatures in Sandra's possession for the above reasons therefore warranted its removal on both occasions".

	Whilst Sandra's Consultant Psychiatrist expressed surprise that Sandra [redacted] possession, nursing staff gave evidence that they would not have expected this to be removed as Sandra was not assessed as being at risk of ligature, although at high risk of suicide, because she had no specific history of ligature use. They referred to a balance between assessing risk and maintaining patient dignity in considering whether to remove items of patient clothing, and that many items can be used as a ligature by the determined user.
4	**CIRCUMSTANCES OF THE DEATH** Sandra Kirk was found unresponsive on the floor of the ensuite bathroom of her bedroom at Cygnet Hospital at 7.55am on the morning of 2nd August 2021 [redacted]. She could not be resuscitated and was declared deceased by attending paramedics at 8.53am.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are: - The evidence in this inquest was that Cygnet's Ligature Risk Reduction Policy and the Ligature Audit Tool/Ligature Risk Assessment are standard documents used by Mental Health inpatient providers, including NHS Psychiatric Trusts. - The Ligature Risk Reduction Policy quotes the CQC guidance of 2015, that "Three-quarters of people who kill themselves whilst on a psychiatric ward do so by hanging or strangulation". - Whilst these documents provide detailed guidance in respect of minimising ligature anchor points, they do not give guidance as to minimising potential ligatures themselves, which are defined as "Any item which can be used to make a loop or noose with the intention of limiting the supply of oxygen to an individual by hanging or asphyxiation". - Rather than emphasising the very real risk that specific items of clothing, [redacted], can pose to vulnerable patients, the document places emphasis on avoiding 'blanket restrictions' which does not assist in identifying where the real risks lie. - Death by the use of a ligature is likely to occur within a few minutes, whereas observations for a high-risk patient not assessed

	as being in immediate crisis, will generally be carried out four times in every hour, which therefore provides only a limited degree of risk reduction. Consideration should be given as to efficacy of such a policy and whether this can be improved by recognising that some items of clothing will be more obvious ligature risks and may need to be removed in all cases. Consideration should be given to whether any steps can be taken to address the above concerns.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to the following: 1. See names in paragraph 1 above 2. [redacted], [redacted] 3. Cygnet Healthcare,[redacted], DAC Beachcroft, [redacted] 4. Surrey and Borders Partnership NHS Foundation Trust, [redacted] 5. Care Quality Commission, [redacted] 6. The Chief Coroner In addition to this report, I am 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 at the time of your response, about the release or

	the publication of your response by the Chief Coroner.
	Signed: **ANNA LOXTON** **DATED this 26th day of September 2022**