Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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THIS REPORT IS BEING SENT TO:

[redacted]
Chief Executive
South West Yorkshire Partnership NHS Foundation Trust
Fieldhead Hospital
Ouchthorpe Lane
Wakefield
WF1 3SP

Copy to the Commissioners for the Service

[redacted]
Head of Commissioning (Mental Health, Learning Disability and Autism)
NHS South Yorkshire Integrated Care Board
Hillder House, 49 – 51 Gawber Road
Barnsley
S75 2PY

1 CORONER

I am Steve Eccleston, Assistant Coroner for the area of South Yorkshire (West)

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 14.12.21, I commenced an investigation into the death of Daniel Eric Lee aged 22. The investigation concluded at the end of the inquest on 08.11.22. The findings of the inquest were that Daniel Lee died on 16.09.21 at a disused quarry [redacted] by hanging [redacted] with the intention to end his life.

The conclusion was suicide.

The medical cause of death was

1a Hanging

4 CIRCUMSTANCES OF THE DEATH

Daniel was under the care of the IHBTT team of SWYPT at the time of his death. He became known to them on 16.07.21 following an attempt to hang himself. He was seen by at least 17 different team members in at least 37 contacts during the two months of his care under the team.

Evidence was given by [redacted] the author of the Serious Incident report commissioned by the Trust that this teams remit was to act as a crisis management and prevention team to avoid people having to be detained under section in hospital. It provides intensive 24/7 contact with people at risk. It was described as a consultant led team.

5 CORONER'S CONCERNS

The MATTERS OF CONCERN are as follows:

5.1 While acknowledging Daniel's high level of contact with the IHBTT team, the evidence was that no one was taking responsibility for his care in a 'key worker' type role. The large number of people seeing Daniel did not make deep professional relationships with him which would allow his needs and risks to be addressed in a person centred and properly risk sensitive way. The relationships with Daniel were superficial and this infected the risk assessment process. The large number of mental health professionals in contact with Daniel inhibited him establishing deep relationships of trust.

5.2 The risk assessments themselves were therefore superficial, often relying uncritically on self-reporting without meaningfully engaging in suicide risk prevention. The initial risk assessment on first contact on 16.07.21 was flawed in that, despite the presenting context being an attempt at suicide by hanging, the risk assessment was 'low risk of suicide'.

5.3 Daniel was a serving soldier and there was a failure to meaningfully communicate and engage with his Regiment and the medical staff attached to it.

5.4 Communication with the family was superficial and the evidence was that their perception was that they couldn't fully share issues and concerns because of perceived barriers in information sharing. This may not have been the team's intention, but it was the reality felt by the family. This inhibited their engagement with the team in Daniel's best interests. The evidence of [redacted] was that engagement with the family was important because they were the people who knew Daniel best and who would be the first to identify any risks or concerns.

5.5 There was evidence that staff in the team struggled with decision making around information sharing. For example, on 15.09.21, the day before he died, Daniel's girlfriend called to share concerns about his wellbeing. The person taking the call indicated that Daniel's lack of knowledge of her referral placed the team in difficulty in sharing the information. In the event, a practitioner saw Daniel for a visit only a few minutes later and correctly identified his need for an urgent psychiatric review. Notwithstanding this, I considered that this was evidence of a failure to understand the basics of risk-based information sharing.

5.6 In summary, therefore, I considered that there was evidence that a failure to address these issues could create a risk of further deaths:

- Superficiality of risk assessments
- Lack of a key worker approach
- Lack of communication with the armed forces, army in this case
- Superficiality of communication with the family
- Anxiety about appropriate risk sharing

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 16.02.23 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 family of Daniel (Interested Persons) and to the Head of Commissioning (Mental Health, Learning Disability and Autism) NHS South Yorkshire Integrated Care Board as Commissioner. 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.

21st November 2022

Steve Eccleston
HM Assistant Coroner