REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Victoria Aitkins, Secretary of State for Health and Social Care, Department of Health and Social Care, 39 Victoria Street, London SW1H 0EU. 2. [redacted], Chief Executive, NHS England, PO Box 16738, Redditch B97 9PT
1	**CORONER** I am Andrew Bridgman, Assistant Coroner, for the coroner area of South Manchester
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 18.09.23 an investigation commenced into the death of Amina Ahmed Ismail who died on 15.09.23 at Pankhurst Ward, Priory Hospital Cheadle, aged 19 years having been born on 08.06.03. Amina had self-ligatured. Pankhurst Ward is a PICU – where Amina had been a patient from August 2022. **Interested Persons** In addition to Amina's family the Interested Persons were The Priory Hospital, Cheadle Birmingham Women and Children Hospitals NHS FT – otherwise known as Forward Thinking Birmingham ('FTB') Birmingham and Solihull Integrated Care Board ('the ICB'). The inquest was held as an Article 2 inquest with a jury; Amina was a detained patient. The inquest concluded on 16.05.24. **The medical cause of death was:** 1a) Ligature Strangulation 1b) 1c) 2 Emotionally Unstable Personality Disorder, Post Traumatic Stress Disorder **The conclusion of the jury was:** *Misadventure* In answer to the question how Amina came by her death the jury recorded: [redacted]. *Amina was ready for step-down in September 2022, but was subject to a prolonged stay on the PICU ward due to the shortage of appropriate, specialist care beds. Amina's mental health deteriorated during her long PICU stay. These factors contributed to the circumstances of Amina's death.*
4	**CIRCUMSTANCES OF THE DEATH** Amina lived in Birmingham. At the age of 15 years Amina was admitted to Orchard

	Ward, Priory Hospital Cheadle (adolescent acute ward) on 02.01.19, under section 2 of the MHA 1983, following an overdose, and then section 3 of the Act. From there Amina's journey was to Mulberry Unit, Priory Hospital Woodbourne (adolescent acute ward) in February 2019, from there to Meadows Unit, Priory Hospital Cheadle (adolescent PICU) with discharge back into the community in September 2019. Amina was admitted to Pegasus Ward, Cygnet Sheffield (adolescent acute ward) on 18.06.20, aged 17 years, following an overdose of her medications under section 2 of the Act From then until her death, some 2 years 3 months later, Amima was a detained patient on mental health units distant from her home, family and friends. On 23.07.20 Amina was transferred from Pegasus Ward to Unicorn, Cygnet Sheffield, A PICU, where she remained for 5 months. In December 2020 Amina was transferred to a low secure unit in Ebbw Vale, South Wales, where she stabilised. On 22.11.21 Amina was transferred to a specialist Personality Disorder Unit at Cygnet Nield House, Crewe to commence Dialectical Behavioural Therapy (DBT). In mid-June 2020 Amina's mental health deteriorated and her incidents of self-harm worsened. Nield House advised FTB ('the home team') that it could no longer keep Amina safe and that a PICU was required. It took until 01.08.22 for FTB to locate a PICU that was able to, and would, accept Amina. On 02.08.22 Amina was transferred to The Priory Hospital, Cheadle. Other than her brief time at The Priory Hospital, Woodbourne all of Amina's placements were out-of-area. Amina was ready for step-down from the PICU, at The Priory Cheadle, in early September 2022. Nield House would not re-admit Amina without a further assessment, and in any event, had Amina then been accepted FTB would have needed to re-apply to the ICB for funding of her placement at Nield House. FTB decided to carry out a PACT assessment to re-determine Amina's needs in order to ensure that the next placement would be the most appropriate. Failure of another rehabilitation placement would be devastating for Amina. That assessment was commenced in October 2022 and was complete by early January 2023. There was consideration of Fern Unit, a specialist Personality Disorder Unit at Priory Cheadle but it was felt that its DBT programme was too rigid for Amina's needs. Following completion of the assessment FTB sought a suitable rehabilitation placement. At the time only two independent providers had capacity to take Amina. One of those, Cygnet Alders Ward turned Amina down as it did not think Amina was sufficiently stable. The other one, Equilibrium Eleanor House in Manchester. was prepared to accept Amina after carrying out its own assessment. On 15.03.23 the FTB applied to the ICB for funding to transfer Amina to Eleanor House, which at the time had voluntarily closed itself to patients following a CQC rating of overall inadequate, and was appealing a Notice of Decision, to be heard in June 2023. The application was turned down by the ICB on 04.05.23. The ICB provided the FTB with 3 other potential placements, Cygnet Kewstoke: Weston-Super-Mare Elysium Gateway: Widnes Priory Middleton St George: Durham. None of these units were prepared to consider Amina because of the acuity of their

	current patients. Upon being told that funding for Eleanor House had been declined there was a significant downturn in Amina's mental stability evidenced by a re-emergence of ligaturing as a coping mechanism, and for the following 10 weeks was monitored on enhanced level observations. By mid-July Amina had stabilised. During that period the option of transferring Amina to a local PICU, with input from the local mental health in-reach team was explored, but there were no local PICU female beds available. There being only 6 such beds locally, commissioned exclusively by FTB at The Priory, Barnt Green. In July 2023 The Priory (the treating team) and FTB (the home team) and Amina felt that she was stuck. Further consideration was given to Fern Unit. Following assessment, and with some flexibility introduced into the DBT programme, Amina was accepted by Fern Unit on 31.08.23. At a Ward Round on 06.09.23 both the Pankhurst Ward team and FTB felt that the transfer would be appropriate. Amima was noted to be looking forwards to the move. A peer from Pankhurst Ward had already been transferred. Although a bed was immediately available FTB needed to complete an application for funding the Fern Unit to the ICB. That had not been commenced at the time of Amina's death but had it been it is unlikely, even if commenced on 06.09, that funding would have been approved in time to allow transfer before her death. The evidence of the Responsible Clinician at The Priory, Cheadle and the Court appointed expert was that there was an overall deterioration in Amina's mental health during her prolonged admission on the PICU; it was not an appropriate environment, she was not able to have the necessary therapy, although Amina received psychological input it was limited (by the fact of being in PICU) and by July/August Amina had stopped learning and was not using coping mechanisms that she had developed in her psychology sessions.
5	**<u>CORONER'S CONCERNS</u>** 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. – This is now the third inquest (two within the past 8 months) I have heard where the delayed transfer of an out-of-area patient from an independent provider's hospital has been a contributory factor in that patient's death. Two of those cases involving prolonged stays on PICU units; in this case some 13 months and in the other, some 11 months. These cases illustrate, a) Underfunding for local mental health beds. It took some 6 weeks in 2022 to transfer Amina from the PD specialist placement at Nield House (where the treating team felt that they could not keep Amina safe) to a PICU some 90 miles from home. Further, there were no local PICU beds available for transfer out of The Priory, Cheadle in May/June/July 2023 when a PD placement could not be found. b) An over-reliance by the NHS on independent providers for mental health beds whether general acute beds, PICU beds or specialist units. c) A national scarcity of specialist PD rehabilitation units The inquest heard evidence from treating two treating psychiatrists in Amina's

	history (Nield House and The Priory), FTB PACT assessor, and the court appointed independent expert that there was, and is, a national shortage of specialist PD rehabilitation units/beds, paraphrasing, '*rehabilitation beds for female patients with PD are limited – demand exceeding what is available nationally'.* *'shortage of rehabilitation placements nationally – impeding on young persons' mental health treatments'* *'simply not enough beds (NHS or Independent) to cater for such complex patients as Amina – transfers not being accepted by such units even if not full because the acuity of their existing patients'.* *'PD rehabilitation beds are scarce – spread nationally often in isolated units far from home, family and the local/home team. Each having its own admission criteria/exclusions, such as the possible need for NGT feeding'.* Following the PACT assessment FTB, in early 2023, were only able to find two PD units that had a bed available. One of them, Eleanor House, was re-opening its doors having voluntarily closed at the end of 2022. It had 14 beds available. However, its extant CQC rating was overall inadequate and it was in the process of appealing a Notice of Decision. The other, Cygnet Alders, declined the referral. Three other units were identified as possibilities but each declined a referral, without any assessment, based on the acuity of their own patients. Just 5 beds available over a period 6-7months, before Fern Unit accepted Amina. In the meantime Amina remained in a PICU, some 90 miles from home which was wholly unsuited to her presentation and unable (through no fault of its own) to deliver the care and therapy that she needed resulting in a deterioration in her mental state with increasing risks/incidents of self-harm. d) A funding process for rehabilitation units that is not fit for purpose. The inquest heard evidence about the funding set-up for secondary mental health care in the Birmingham area, which is replicated nationally. The ICB commissioned FTB to provide secondary mental health services, both community and in-patient. FTB are able to commission NHS and independent sector acute beds and PICU's, both in and out of area. However, FTB are not able to commission specialist placement, including PD units. These are commissioned/funded directly by the ICB upon application by the FTB; having found a unit that would accept a patient. This system, for funding specialist/rehabilitation beds, is inadequate; particularly in light of the shortage of such specialist/rehabilitation beds. The inquest heard evidence that the process from application to funding approval takes weeks, sometimes months. In this case it took from 13.03.23 to 04.05.23 for a negative outcome. The shortage of beds/units means that when a bed becomes available there are a number of patients in competition for it. The beds are not kept open for any particular patient and, in essence, allocation becomes a race on funding. It is surprising that a 'home team' (in this case FTB) commissioned by an ICB to provide secondary mental health services is not permitted to make its own funding decisions for specialist units, as it can for acute wards and PICU's. As can be seen from the evidence Amina was able to be transferred within 24hrs once a PICU accepted her on 01.08.23, albeit it took a wholly unsatisfactory 6 weeks to find a PICU bed.
6	**ACTION SHOULD BE TAKEN** Unless action is taken to increase the number of mental health beds (beds, PICU) and in particular specialist/rehabilitation units, in general but particularly within area, more of

	our most vulnerable members of society are going to be sent to mental health units unacceptably distant from their homes, family and friends, be unable to receive the treatment they need, suffer an associated deterioration in their mental state with an increased risk of deliberate or accidental self-inflicted death. In my opinion action should be taken to prevent future deaths and I believe you 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. 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 namely, who may find it useful or of interest. 1. Amina's family 2. The Priory Cheadle 3. Birmingham Women and Children Hospitals NHS FT – otherwise known as Forward Thinking Birmingham 4. Birmingham and Solihull Integrated Care Board. 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 this 14th day of June 2024**  **Andrew Bridgman** **HM Assistant Coroner**