REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. NHS Improvement, Patient Safety Team, Skipton House. 80 London Road, London, SE 1 6LH ([redacted])
1	**CORONER** I am Anita Bhardwaj, Area Coroner for the 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 18th May 2019 I commenced an investigation into the death of Ceara Marie Thacker, aged 19 years. The investigation concluded at the end of the inquest on 20th September 2019. The conclusion of the inquest was as follows: **Ceara Marie Thacker died as a result of Suicide** Ceara Marie Thacker died from: **Ia Compression of the Neck (Due to)** **b Hanging**
4	Ceara Marie Thacker was a 19 year old young lady who moved from Bradford to Liverpool in September 2017 to attend the University of Liverpool. Up until the age of 16 Ceara had been under Child and Adolescent Mental Health Services (CAMHS) in Bradford. Throughout her teenage years Ceara self-harmed. On 11 May 2018 Ceara was found deceased hanging [redacted]. The toxicological analysis revealed the presence of alcohol (175mg – blood). Ceara's first contact with mental health services in Liverpool was with the Primary Care Service, Talk Liverpool, in September 2017. Ceara registered with a GP in Liverpool on 30 September 2017. On 3 October 2017 Ceara presented herself at the Accident and Emergency department of the Royal Liverpool University Hospital with suicidal ideation and was low in mood. During the assessment in the Royal Liverpool University Hospital (RLUH) a mental state examination was completed which concluded Ceara was low and anxious, however had no current plan or intent to end her life, citing her family and friends as protective factors. The plan developed was for Ceara to see her G.P. to review her treatment, she was provided information and was signposted to Young Persons Advisory Service (YPAS). On 23 October 2017 Ceara saw the GP and discussed her anxiety and depression, she was noted to be coping mostly well but stated she could sometimes get very low. On 21

	February 2018, Ceara attended the Royal Hospital accident and emergency department having overdosed on paracetamol and ibuprofen and once medically fit she was assessed by the mental health practitioner. During the assessment Ceara stated she had been struggling and her level of self-harm had increased but was unable to identify a trigger. Ceara was given similar advice again to when she attended the Accident and Emergency Department in October 2017. Ceara stated she found it difficult to take the medication and that it was not effective and did not like the way it made her feel. She was advised to discuss this with her G.P. who could discuss alternatives. The assessment noted that Ceara's self-harm had increased in frequency and concluded that she had taken an impulsive overdose and she regretted taking the overdose. Despite stating she had good friends the note of the assessment later stated that friends were unaware and that she didn't feel she knew them well enough to talk about her difficulties (the assessment was never sent to the GP but this was a separate issue explored at the Inquest). On 13 February 2018 Ceara completed and dated a self-referral form to the Mental Health Advisory team, a service based in the University of Liverpool and supplementary to the NHS mental health services, but only sent the form to them on 22 February 2018, the day after she had taken the overdose. This referral was triaged on 26 March 2018 and an appointment then offered for 24 April 2018 (the delay of the appointment was a separate issue explored at the inquest). In this meeting she mentioned similar things to those mentioned in previous meetings. Ceara was not deemed to be of immediate risk. On 24 March 2018 Ceara completed a second self-referral to Talk Liverpool and was offered a telephone assessment for 10 April 2018. This was carried out by a cognitive behavioral therapist. This assessment concluded that Ceara presented as quite vulnerable and impulsive and reached the conclusion that Ceara was not suitable for cognitive therapy behavior therapy and referred her to a secondary service, the Single Point Access (SPA) team for a full mental health assessment. The referral to SPA team was received on the same day and was triaged the next day on 12 April 2018. The assessment is based upon the information on the referral and at a multi-disciplinary team meeting it was deemed suitable for a routine appointment namely in 6 weeks and Ceara was sent an appointment for 18 May 2018. Ceara did not attend this appointment as she died on 11 May 2018. A number of other issues gave rise to exploration during the inquest, however, these were not matters relevant to this report.

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. Throughout Ceara's Involvement with the medical professionals and therapists, whether by Mersey Care, Mental Health Advisory team at the University or the GPs there is no evidence of any discussion around involving Ceara's family in drawing up a plan or consideration of requesting consent from Ceara to discuss her situation with parents/family. It is accepted that Ceara was an adult and had full capacity, however, Ceara was a young adult, first time away from home who had history of mental health issues. It would have been helpful to have had these discussions so that if Ceara wanted that additional support from her family this could have been facilitated. That said it is unclear as to whether Ceara would have agreed to her family being involved, however, this line of enquiry would have been helpful.

   The general approach with young people appears to be to encourage them to discuss their issues with their parents/family rather than asking for consent for the professionals to discuss it with the parents/family.

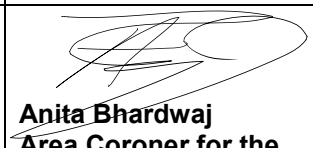
2. Concern was raised that once Ceara was found hanging, no attempts were made to cut her down. The pathologist gave evidence to the effect it would be difficult to say how quick the death would have occurred, however, there was a very small window after the hanging where a person could survive, be it with brain damage. He stated it was rare that an individual was not cut down. The Residential Adviser who found Ceara had received first aid training but this did not include anything in relation to hangings.

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.

1. Consideration be given to the merits of incorporating into training, guidance or publications for health professionals, the importance and benefits of requesting consent from young, vulnerable adults to involve their parents/family in their mental health care plan; whether this is by way of including a question in assessment toolkits to prompt this discussion with the young adult or other methods.

2. Consideration be given to including any appropriate training or information that can be incorporated into the national first aid training on what to do when someone is found hanging (it is accepted that individuals at the time may not be able to follow any guidance depending upon their reaction to the situation).

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, but in any event before the **22nd November 2019**. 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: • The Family of Ceara Marie Thacker • Mersey Care NHS Trust • Brownlow Hill Medical Group 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	 **Anita Bhardwaj** **Area Coroner for the** **City of Liverpool** **Dated: 30 September 2019**