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. **Avon & Wiltshire Mental Health Partnership NHS Trust** 2. [redacted] **mother of deceased** 3. **Care Quality Commission** 4. **Chief Coroner**
1	**CORONER** I am Dr. P. Harrowing, LLM, Assistant Coroner, for the Area of Avon
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 28th March 2014 I commenced an investigation into the death of **Kimberley Jane Elizabeth PARSONS**, Aged **23**. The investigation concluded at the end of the inquest on 6th February. The conclusion of the Jury was that the medical cause of death was 1a) Hypoxic brain injury; 1b) Hanging and the conclusion was that of an Accidental death.
4	**CIRCUMSTANCES OF THE DEATH** Since 2008 Ms. Parsons had suffered with mental health problems with suicidal ideation. In 2010 she was diagnosed with borderline personality disorder and in May 2010 she was admitted for the first time to Sycamore Ward, Hillview Lodge, Bath owing to suicidal intent. From that time until early 2014 Ms. Parsons took a number of overdoses of medication, self-harmed by cutting herself as well as trying to set herself on fire. Following earlier admissions to Sycamore Ward in August 2013, November 2013 and January 2014 Ms. Parsons was again admitted to Sycamore Ward, Hillview Lodge, Bath under Section 2, Mental Health Act 1983 on 7th March 2014. On admission it was noted that she had a high level of risk of self-harm in the context of a relapse of her mental health condition. Her prescribed medication on admission was mirtazapine tablets 45mg once daily, quetiapine tablets 50mg once daily and lorazepam 1 - 2 mg when required (within the dosage range of the British National Formulary). Ms. Parsons remained very distressed, low in mood and expressing a wish to die. On 9th March 2014 Ms. Parsons self-harmed on the ward by cutting her wrist with broken crockery. The wounds were treated appropriately by nursing staff on the ward. [redacted] Consultant Psychiatrist, reported that Ms. Parsons continued to express strong suicidal desires and was not wishing to engage. On 12th March 2014 the staff nurse noted that Ms. Parsons had again self-harmed on the ward and had used a piece of broken crockery she had found in the garden to make a superficial cut to her wrist. On 14th March 2014 [redacted] Ward Manager, Sycamore Ward, discussed with Ms. Parsons her recent attempts at self-harm on the ward and asked her how best she could be prevented from coming to harm and to prevent her presentation from escalating. In evidence [redacted] stated that she asked Ms. Parsons whether "...staff allowing and supporting her to self-harm help her in any way, would it ease frustration, anger or urges to harm herself...". [redacted] referred to 'evidence' suggesting that this approach can reduce the risk of infection by avoiding the person using dirty utensils and also that trying to stop an individual from self-harming could lead to "...more fatal and explorative methods of harming...". However, in evidence [redacted] was unable to identify any other examples where

	this approach had been adopted in the unit and she could not provide any references to peer-reviewed papers published in the professional literature. Importantly [redacted] accepted that she had not discussed this matter with [redacted] or any of the other medical staff, neither prior to nor after, her discussion with Ms. Parsons. In addition she made no record of the discussion in the medical records. [redacted] was asked whether he was aware of any evidence of this approach being adopted in such patients and in evidence he confirmed that he was not aware of any published papers in the professional journals to which he had access. Notwithstanding this discussion between [redacted] and Ms. Parsons there was no evidence that subsequently there had been any assistance provided to Ms. Parsons in the manner described by [redacted] During the early hours of 16th March 2014 Ms. Parsons was found hanging in her room having used an item of clothing as a ligature. Attempts at resuscitation were undertaken by ward staff and the paramedics were summoned. Ms. Parsons was transferred to the Royal United Hospital, Bath where she was admitted to the Intensive Care Unit. However, despite all efforts she died as a result of her injuries on 24th March 2014.
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) The suggestion made to Ms. Parsons, a person with a history of self harming and who remained at high risk of self-harming, that she could be assisted with self-harming was not an approach to patient care and treatment which was supported by any reference to the results of any research published in a peer-reviewed professional journal. Therefore if this is a *bona fide* approach to treatment in a high risk patient then the Trust should be able to justify that this is a recognised and generally accepted practice by reference to the published literature and/or results of published research. (2) If the Trust cannot provide evidence to support this treatment being a recognised and generally accepted practice then the Trust must establish proper procedures for the introduction and use of novel treatments including the obtaining of any necessary ethical approvals. (3) This discussion with regard to 'assisted self-harming' was not discussed by the nurse with the consultant psychiatrist nor was any record made of the discussion. The Trust should undertake a proper review of any training with respect to these matters so as to ensure any discussions with regard to proposed treatment are had with the full knowledge and agreement of the consultant in charge and that those discussions are properly recorded.
6	**ACTION SHOULD BE TAKEN** 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, namely by 29th April 2015. 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 [redacted] mother of the deceased, and the Care Quality Commission. I shall a copy of your response to [redacted] and the Care Quality Commission. I have sent a copy of my report to the Chief Coroner.

	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	**4th March 2015**	**Assistant Coroner** [redacted]