In the South London Coroner's Court

Inquest touching the death of Christopher Brennan

Report to Prevent Future Deaths (*Coroners (Investigations) Regulation 28)*

	THIS REPORT IS BEING SENT TO: 1. **Resuscitation Council (UK)** 2. **South London and Maudsley NHS Foundation Trust**
1	**CORONER** I am Selena Lynch senior coroner for the coroner area of South London
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 2nd September 2014 I commenced an investigation into the death of Christopher Brennan, age 15. The investigation concluded at the end of the inquest on 21st September 2016. The conclusion of the inquest was that Christopher died from asphyxia due to acute upper airway obstruction. The circumstances in which he came by his death were recorded by the jury in a narrative form, as follows: Christopher suffered from mental illness and was a patient at Bethlem Adolescent Unit at the Bethlem Royal Hospital, Beckenham. He had a history of hearing voices, suicidal ideas, and self harm, usually by swallowing objects. On 31st August 2014 at about 8 pm, Christopher went to the communal toilet on the unit and obstructed his airway by swallowing the lid of a roll on deodorant wrapped in tissue paper. He called for help but suffered a cardiac arrest before the obstruction could be removed, and could not be resuscitated. Christopher's actions were in part because of cumulative and continuing failures in risk assessment and management. His death was contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Please see the narrative conclusion set out in paragraph 3, above
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) In respect of the in-patient management: that there was no separate policy or guidance, other than a pictorial wall chart, regarding the assessment and management of risks posed by items that might be used to cause self harm. The complexities of managing these risks on an adolescent in-patient psychiatric unit were not therefore adequately considered, and this led to a lack of clarity and consistency. (2) With regard to resuscitation: the emergency equipment on the unit did not include a laryngoscope. The item obstructing Christopher's airway was subsequently used by ambulance personnel using Magill forceps with a laryngoscope, and this combination had been successfully used on a previous occasion when Christopher had swallowed a bottle top. Laryngoscopes are not part of the standardised items on the unit, and are not included in the Resuscitation Council guidance for mental healthcare settings. It has been suggested that this is because they are complex devices that require intense training and competency assessments before staff can use them, and that it may be counterproductive to make them available. However, in view of the circumstances of Christopher's death, and the apparent prevalence of self harm in adolescent units, the matter is reported for consideration, both in relation to the laryngoscope itself and the access to staff trained in its use.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisations 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 **1st February 2017.** 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 Christopher Brennan, and Oxleas NHS Foundation Trust; and to the local Safeguarding Children 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	**DATE** 5th December 2016 **SIGNED BY CORONER** Sinead Lynch