



HER MAJESTY'S SENIOR CORONER

For the Counties of Kingston upon Hull and the East Riding of Yorkshire

Professor Paul Marks BA LL M MD FRCS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO: NHS Improvement</p> <p>email: [REDACTED]</p>
1	<p>CORONER</p> <p>I am Professor Paul Marks BA LL M MD FRCS Senior Coroner for East Riding and Kingston-upon-Hull</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 14/05/2015 I commenced an investigation into the death of Helen Louise MILLARD. The investigation concluded at the end of the inquest 26th September 2016. The conclusion of the inquest was Accidental Death.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>At between 18.32 & 18.59 on the 12th May 2015, the deceased hanged herself using the taps in a bathroom at the Westlands Mental Health Unit, Hull. She died at the Hull Royal Infirmary at 01.28 on the 13th May 2015.</p>

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. –

Evidence was heard that NHS England is undertaking an ongoing programme of work to eliminate ligature points in in-patient and other psychiatric facilities. It was established that a 'traffic light' system is in operation which prioritises the work once a ligature point has been identified in any particular facility. The Court heard that if a point is scored 'red' this equates with an extreme risk and mandates urgent elimination of the point. If, however, a risk is categorised as 'amber' this nevertheless represents a high risk. The classification according to this traffic light system is based upon the height of the ligature point from the ground. If a ligature point is one metre or less it is categorised as being 'amber', whereas if it is over one metre above the ground it is categorised as 'red'.

Expert evidence was adduced from a number of expert witnesses and Consultant Psychiatrists that at least 50% of deaths due to hanging in inpatient psychiatric facilities occur from ligature points which are one metre or less in height above the ground. Patients merely need to learn forward and tighten the ligature around their neck under their body weight and they collapse into unconsciousness within ten to twenty seconds and death can occur in as little as two to three minutes. This evidence was backed up by peer reviewed literature which was also read out during the course of the Inquest.

My principal concern is that there is an obvious incongruity in the classification system as effectively all ligature points, no matter what their height, should be regarded as representing extreme risks. Evidence was heard that the risk is independent of height and consideration needs to be given to classifying all ligature points once identified as 'red' and their elimination tackled on an urgent basis.

6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you I have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 1st December 2016. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <ol style="list-style-type: none">1. [REDACTED] Howells Solicitors;2. [REDACTED] DAC Beachcroft LLP <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>06/10/2016</p> <p>Signature </p> <p>Professor Paul Marks BA LLM MD FRCS Senior Coroner East Riding and Kingston-Upon-Hull</p>