	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr Stuart Bell CBE, Chief Executive of Oxford Health NHS Foundation Trust**
1	**CORONER** I am Mr D M Salter, HM Senior Coroner for Oxfordshire.
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** I concluded the inquest into the sad death of Liam Thomas at Oxford Coroner's Court on 28th July 2017. Mr Thomas died at Littlemore Hospital Oxford on 28th August 2016. The jury returned a narrative conclusion as follows: *Liam was found in a shower room of the Phoenix Ward of Littlemore Hospital with plastic bags over his head, secured in place with a shoelace, at about 14:00 on the 28th August 2016, and pronounced dead at 15:21 at the John Radcliffe Hospital the same day. The cause of death was asphyxiation.* *At this time, Liam intended to take his own life. This intention was formed at a time when his mind was disturbed and the following inadequacies in the provision of mental health care at Littlemore Hospital contributed to his death: failure to ensure patients safety in relation to a banned item (plastic bags) and failure to manage items identified by staff to be of individual personal risk to Liam (ligature items).* There was written and oral evidence at the inquest which included evidence from nursing staff and doctors from the Trust together with [redacted], Head of Nursing for the Adult Directorate. The Trust were legally represented at the inquest. A full copy of the inquest file was provided in advance. I have not therefore provided you with a full copy of the inquest file with this letter.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances are briefly set out above in the narrative conclusion. As you will know, Liam was 21 years old when he died on 28 August 2016. CPR was carried out and he was taken to the John Radcliffe Hospital by ambulance but he was pronounced death soon after arrival. He was a single man who lived with his mother and sister in Didcot. He worked in ICT as a Programming Developer. Liam had suffered with mental health problems before his death including thoughts of taking his own life. He was detained under Section 2 of The Mental Health Act 1983 on 11th August 2016 and remained an inpatient on the Phoenix Ward at Littlemore hospital until his sad death.

5	CORONER'S CONCERNS **During the course of the Inquest the evidence revealed matters giving rise to concerns. 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 make this report to you.** The **MATTERS OF CONCERN** are in relation to plastic bags/restricted items and, secondly, communications with family. I recognise that lessons have already been learnt following Liam's death as set out in the Route Cause Analysis investigation and, specifically, in the action plan. Ms Klink gave further evidence about this. In relation to the first concern, about plastic bags as restricted items on the ward, the sad fact is that Liam was able to take his own life because he had access to plastic bags. They were Sainsbury's bags. He attended Sainsbury's on Section 17 leave two days prior to his death. There was evidence that these bags were taken from him on return to the ward. It could not be ascertained if this was correct and whether the bags which Liam used were bags which he obtained on the trip to Sainsbury's or whether the bags were obtained in some other way on the ward. I understand there have been improvements in the system in relation to plastic bags in particular. I appreciate however that the problem of plastic bags is not straight forward, particularly when one takes into account the fact that many patients are informal patients and are free to leave and return and that visitors may also bring plastic bags when visiting. I understand that there are clear warnings that plastic bags are restricted items at the entrance to the ward and that steps are taken to bring this to the attention of visitors. It would be helpful if I could be provided with further details about the steps that are in place. A related concern was the environmental searches that were intended, amongst other things, to check for plastic bags. I was shown what are referred to as daily environmental safety check lists which include plastic bags/bin liners on them. I had the impression from the evidence that, at the time, these checks were not being carried out as regularly as they should be. Indeed, I see that recommendation 2 on the RCA/Action Plan concerns standardising the frequency of environmental checks and monitoring of banned items across all in patient wards. It states that they should be carried out daily. It appears a policy is in place and a recommendation but it is not clear to me whether there is effective implementation. Consequently I request that this matter be reviewed and that I receive a response specifically about implementation. The second area of concern is about communication with family. Again, I realise that this is not a straightforward matter because there are issues of consent and it is also the case that some families are not supportive or united. However, in Liam's case, it is clear that his family were very supportive and united in terms of Liam's health and wellbeing. A concern at inquest from the evidence was that there was a need for improved communication in terms of information provided by family to staff and also from the staff (particularly concerning elevated risk) to family members. This will enable family to be more watchful. [redacted] in her evidence, referred to the "triangular approach" and recognised that there was more work to be done in this difficult area. She indicated that work was on going. It would be helpful if you could provide details about the current policy and practice concerning communications with family and if there is a programme in place, to improve it.

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. I may extend the period on request. 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 confirm that a copy of this report and your response will be sent to Liam's family. 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	**Signed** **Date** 4th September 2017 Mr D.M. Salter **HM Senior Coroner for Oxfordshire**