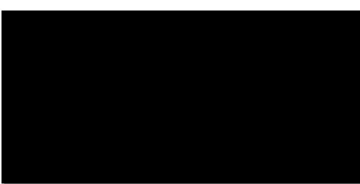
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Professor Stephen Powis, National Medical Director, NHS England, Skipton House, 80, London Road, London. SE1 6LH. Rt Hon Matt Hancock MP Secretary of State for Health Department of Health 39 Victoria Street London. SW1H 0EU. Paul Rees, CEO Royal College of Psychiatrists 21 Prescot Street, London. E1 8BB [redacted] CNWL CCG Chair Central & North West London NHS Foundation Trust HQ Stephenson House 75 Hampstead Road London. NW1 2PL
1	**CORONER** I am Dr Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West 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 the 3rd October 2018, evidence was heard touching the death of **Maximilien Conrad Kohler.** Max had been found deceased hanging by a belt around his neck from a pull-up bar positioned across his bedroom door at his home address. He was 15 years old at the time of his death. The findings of the court were as follows: **Medical Cause of Death** 1 (a) Fatal pressure to the neck

	How, when and where the deceased came by his death: Max suffered with Autistic Spectrum Disorder and Attention Deficit Syndrome. At times symptoms of ASD would overwhelm him and he would attempt to take his own life or self-harm. On 5/5/2018 he was found hanging by his father at his home address. Despite resuscitation his life could not be saved and he was recognised as life extinct at 07:23. He had left 2 messages expressing intent and demonstrating capacity. **Conclusion of the Coroner as to the death:** He took his own life whilst suffering from Autistic Spectrum Disorder
4	**Circumstances of the Death.** Evidence taken at the inquest confirmed that Max had not been diagnosed with ASD until he saw a third and very experienced Child and Adult Psychiatrist, at least in part because Max was clever and able to cross compensate for the issues that the ASD caused him and instead had been incorrectly diagnosed with depression and bulimia nervosa, of which there was no evidence when he was assessed at length in an inpatient setting. These diagnoses had at least in part been arrived at by the use of questionnaires. Expert evidence was taken and accepted by the court that the earlier misdiagnosis may have been contributed to by the latest fashion in mental health to over rely on questionnaires and perhaps less upon clinical evaluation of the whole picture presented by the patient. It is possible that such over-reliance can contribute to misdiagnoses and underestimate risk. The over reliance on the use of questionnaires to assess the risk of self-harm, compared to full psychiatric history taking and evaluation of the patient in the round by a clinician with experience has been a repeated theme in inquests. It was also discussed and accepted by the court that the current training regime for the training of specialist doctors is shorter that it was in the past so that doctors now become consultants with far less experience at senior registrar level, and consequently less exposure to and skill with diagnostics across the range of psychiatric conditions. Further it was discussed and accepted by the court that there is a relative paucity of services for conditions which are chronic and difficult to treat and cure compared to illnesses which respond to short term therapies, and so show easily auditable improvements in health with the application of evidence based guidance. This was considered by the expert and accepted by the court to reflect the style of commissioning of care by CCGs who wish to support and prioritise the services to relatively easily treatable conditions. ASD was accepted to be a lifelong incurable condition which responds only to long term supportive care, and so to have expensive and resource rich treatment requirements. As such ASD would come towards the bottom of the pile for CCG commissioned treatment and care. The expert stated that care provision is even worse for adults with ASD and other similar conditions than for children. Max's parents gave extensive evidence in relation to the support and information that they have received since his suicide compared to the time when they were trying to care for him whilst he was alive. They described a lacuna in support and educational provision for parents attempting to assist a child with ASD. When Max needed urgent in patient admission there was no bed available in London in Child and Adolescent psychiatric services, and if his parents had not been able to access private health care he would have needed to have been hospitalised in Sheffield.

	A report from CNWL, accepted by the court, stated that a new facility is currently being built to provide psychiatric beds for children and adolescents in West London, but this cannot alone address the scarcity of provision across the rest of London and England.
5	**Concerns of the Coroner:** 1. That delays in diagnosis and misdiagnosis in medicine due to reduced time in training for doctors in general and psychiatry in particular, may imperil the lives of vulnerable patients. 2. That over reliance in the current fashion on questionnaires used in diagnostics and management may impede rather than assist doctors and other clinicians, firstly to arrive at the correct diagnosis in the first place, and secondly to cause or contribute to underestimation or proper evaluation of the risk of self -harm in particular. 3. That the NHS care commissioning structure is biased against the commissioning of services for chronic incurable conditions in general and ASD in particular. 4. That there is a lack of support and education available for parents caring for children with ASD. 5. That there is a severe shortage of inpatient psychiatric beds for children and adolescents in the NHS. 6. That services for adults with ASD are even less well provided for by the NHS than those for children.
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. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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 :  2. Chief Operating Officer, Central and North West London NHS Foundation Trust, Stephenson House, 75, Hampstead Road, London. NW1 2PL.

	I have also sent it to the following persons who may it useful or of interest: 3. [redacted] Nightingale Hospital, 11-19 Lisson Grove, London. NW1 6SH. 4. [redacted] CNWL, 7a, Woodfield Road, London. W9 2NW. 5. [redacted] Consultant Paediatrician, St Mary's Hospital, Praed Street, London. W2 1NY. 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	**24th October 2018** **Dr Fiona J Wilcox** **HM Senior Coroner** **Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED**