Regulation 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1. The Medical Director, The Sheffield Children's Hospital
2. The Chief Executive, The Clinical Commissioning Group (CCG), Sheffield

1 CORONER

Stephen Eccleston, Assistant Coroner for the area of South Yorkshire (West)

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 9th March 2018, I commenced an investigation into the death of Aryan Akhgar aged 17. The investigation concluded at the end of the inquest on 25th January 2019. The conclusion of the inquest was:

Narrative Conclusion

Aryan Akghar died on 06.03.18 in the Northern General Hospital Sheffield following an incident on 16.02.18 when he hanged himself from a self-administered ligature with the intent to take his own life.

Aryan's death occurred against a background of four serious attempts to take his own life on 03.01.18, 06.01.18, 09.01.18 and 11.01.18. Aryan was assessed on 09.01.18 by specialists from the Adult Mental Health Trust in the Northern General Hospital Sheffield and discharged home to his family. That assessment recommended an urgent response and visit the next day by the Home Treatment Team. The Home Treatment Team declined the referral because Aryan was under 18. The STAR team in CAMHS did not at that time provide an urgent response service. The first visit by mental health professionals to Aryan therefore was not until 15.01.18 because of this gap in provision.

Aryan was seen by the STAR Deliberate Self Harm team on 15.01.18, 21.01.18 and 03.02.18 and was then discharged. Aryan then hanged himself on 16.02.18.

4 CIRCUMSTANCES OF THE DEATH

Please see the narrative conclusion set out in box 3.

Aryan's medical cause of death was due to hanging. All witnesses accepted that there was a gap in services for Aryan and, notwithstanding the evidence of the Medical Director of the Sheffield Children's Hospital, I remained concerned that difficulties in securing funding might jeopardise his proposed solution.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

5.1 A gap in services was identified for 16 and 17 years old's with urgent mental health issues, such as Aryan had. On 9th January 2018, Aryan was assessed as requiring urgent mental health input, commencing the next day. This was not available as a service for under 18's in Sheffield and Aryan did not receive any contact from Child and Adolescent Mental Health Services (CAMHS) until 15th January 2018. In evidence I was told that additional resources in the CAMHS service were close to agreement in order to prevent this kind of problem arising in the future. However, this would be subject to a commissioning process from the Clinical Commissioning Group for Sheffield which could not be guaranteed.

5.2 It was accepted in evidence by the Medical Director of the Sheffield Children's Hospital on behalf of CAMHS that such additional resource was required. The delivery of the necessary funding to properly resource the CAMHS team was not guaranteed.

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.

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 May 2019. 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 family of Aryan Akhgar (Interested Persons). I have also sent it to The CQC who may find it useful or of interest.

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.

Steve Eccleston

Assistant Coroner for
South Yorkshire (West)
Dated: 3rd April 2019