REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive, Norfolk and Suffolk NHS Foundation Trust,**
1	**CORONER** I am Nigel Parsley, Senior Coroner, for the coroner area of Suffolk.
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 10th May 2016 I commenced an investigation into the death of Kerry Hunter The investigation concluded at the end of the inquest on 4th April 2019. The conclusion of the inquest was that of; Suicide The medical cause of death was confirmed as: 1(a) Bronchopneumonia. 1(b) Hypoxic brain injury. 1(c) Insulin overdose.
4	**CIRCUMSTANCES OF THE DEATH** Kerry Hunter died as the result of an overdose of insulin medication she administered to herself on the 9th April 2016. Kerry was found unconscious at her home address by her father and transported to the Ipswich Hospital, Heath Road, Ipswich where she deteriorated over a period of time. She tragically passed away at the Ipswich Hospital at 04.30 on the 1st May 2016. Kerry had a significant history of previous suicide attempts and for a long period of time was receiving treatment from the Norfolk and Suffolk Foundation Trust. Kerry was diagnosed as having Borderline Personality Disorder and her most recent suicide attempt occurred on the 31st March 2016 nine days prior to being found unconscious at her home. Prior to her death Kerry had requested a specific form of treatment for her Borderline Personality Disorder called Dialectic Behavioural Therapy. Although, this treatment was available and Kerry would have been a suitable candidate, this was not recognised at the time and therefore the treatment was not provided by the Norfolk and Suffolk Foundation Trust. Whether or not the provision of Dialectic Behavioural Therapy would have prevented Kerry's death could not be established on the available evidence.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you;

the **MATTERS OF CONCERN** as follows:-

It was heard in evidence that since Kerry's death the Norfolk and Suffolk Foundation Trust have conducted a review of their treatment provision for individuals suffering from Borderline Personality Disorder (BPD).

As a result of this review the Norfolk and Suffolk Foundation Trust are planning to move the Borderline Personality Disorder Service treatment in-house rather than using external providers and will provide Dialectic Behavioural Therapy

This change is currently in the planning stage and at the hearing I formally requested an update when these plans are put into practice. The update is to include details the new policies and procedures in place regarding clarity of communication of information given to those suffering with BPD, the training and development of Norfolk and Suffolk Foundation Trust staff in relation to BPD and the undertaking of formal risk assessment and the completion to the requisite documentation in cases of those suffering with BPD.

During the hearing itself evidence was heard from an expert witness) about one of the facets of those suffering from BPD which was not addressed by the NSFT plans.

Under the proposed new system, in order to access the Norfolk and Suffolk Foundation Trust Borderline Personality Disorder service, those suffering from the condition would have to agree to be transferred for treatment under the Norfolk and Suffolk Foundation Trust Integrated Delivery Team for onward referral to the new bespoke service.

However, explained that the majority of individuals with a diagnosis with BPD will have had significant previous contact with their mental health service providers.

Kerry herself, had had significant history of previous treatments over a number of years (including Cognitive Behavioural Therapy, Cognitive Analytical Therapy, anti-depression medication and anti-psychotic medication), none of which had proved effective.

confirmed that none of these treatments would have been likely to have had a positive therapeutic effect, which in itself would compound the nature of BPD itself.

explained that the cycle of being offered ineffective treatment would enhance the loss of hope and optimism which is a feature of BPD. Another facet of BPD was often an avoidant personality making sufferers unwilling or unable to engage with new individuals or teams.

This being the case, I am concerned that the proposed requirement in the Norfolk and Suffolk Foundation Trust plan (which will require a BPD suffer to agree to a transfer to an Integrated Delivery Team before being placed onto the new service) may prevent some patients gaining the access to the treatment they clearly need.

6 **ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe you 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 20th June 2019. I, the Senior Coroner, may extend the period if I consider it reasonable to do so. 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 Person, [redacted] I am 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**25th April 2019** **Nigel Parsley**