REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

This report is made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

Recipients

This report is being sent to:

- Dr John Devapriam - Medical Director, Worcestershire Health and Care NHS Trust

Coroner

I am Nigel Meadows, HM Senior Coroner for the Manchester City Area

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

Investigation and Inquest

On 22 May 2018 I commenced an investigation into the death of Alistair Patrick McDonald, aged 19 The investigation concluded at the end of the inquest on 5 June 2019.

The cause of death was found to be:

1a Hanging

The conclusion of the inquest was Suicide.

Circumstances of death

The deceased was born on 17 February 1999 and lived in Malvern, Worcestershire with his parents, together with his two brothers He did not suffer any significant physical health condition or illnesses He was a high achiever academically

When he was about 16 years old his mother learned from his then girlfriend that he was expressing very disturbing thoughts His outlook on life and his future seemed very troubled On becoming aware of this, his school suggested that he might consult the 'Relate Counselling Service', but he did not find this helpful and so with the assistance of his parents, he consulted his GP, who was anxious to make an urgent referral to the local CAMHS

He disclosed he was experiencing suicidal ideation, which he repeated when seeing his GP practice in March 2016. The initial referral by his GP was made on 19 January 2016 and he did have a history of inflicting deliberate self-harm The result of this CAMHS referral was that he could be supported by the 'Healthy Minds Service' A second GP referral was made due to the disclosed specific suicidal intent

He was assessed on 12 April 2016 and confirmed his suicidal thoughts, but it did not appear that the wider perspective of a young man who had just turned 17 readily admitting to suicidal ideation, despite his superficial presentation, was recognised as unusual and disturbing It was suggested that he should consider CBT for his anxiety via the Healthy Minds Service, but it was felt that he did not meet the criteria for CAMHS intervention.

He did not apparently have an assessment by a consultant psychiatrist, but what was described as a 'locum CAMHS senior practitioner'. A letter was written to the deceased on 26 April 2016 indicating that he did not meet the 'criteria for CAMHS at present' This acknowledged difficulties in communicating with the deceased and his mother. However, on one interpretation he could have met the criteria set out in a policy document There did not appear to be any clear advice as to what to do should his suicidal feelings persist and that any help he might receive from the Healthy Minds Service was not successful

There did not appear to be any recognition that he could present a superficially positive state of mind, whereas in reality if subject to more detailed assessment by a psychiatrist that might not have been the true picture

There was never any follow-up to check on his progress

In 2017 Alastair came to Manchester to study for a degree in Music Whilst in Manchester, he disclosed to a friend that he was struggling with depression and he was found by his friend on a visit to be actively self-harming He was encouraged to seek help as he was clearly having difficulties of a serious nature in coping with day to day life He did not disclose to his parents his deteriorating state of mental health and he had no point of contact back to CAMHS or other psychiatric services

On 14 May 2018 he was found dead, hanging by a ligature secured to a door frame

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.

1. Whether or not the specific deliberate self-harm or suicidal ideation criteria need to be reviewed and redrafted
2. The lack of a specific plan for referrals to other services which proved unsuccessful
3 The opportunity to take a broader view of the whole position and have an assessment by an experienced psychiatrist.
4 Ensuring a proper line of communication with the patient and the patient's family to ensure appropriate reviews if the patient's mental state deteriorates
5. Obtaining detailed feedback from services the patient is referred to, to check on attendance and progress
6 Recognising that some patients will only make partial disclosure of their true symptomology and history.
7 Loss of opportunity to see the bigger picture, which was of an academically bright student but who nonetheless was disclosing physical self-harm and suicidal intent, as well as an inability to deal with stress or pressure; and have a plan to review and deal with this
8. Ensuring if there were any failed communications with the patient or the family, to have a plan to take specific action to deal with this.

Action should be taken

In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.

1 Review the self-harm and suicidal ideation criteria.
2 Deal with the issues raised in paragraphs 2-8 above.

Your response

You are under a duty to respond to this report within 56 days of the date of this report, namely by 27 September 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

Copies and publication

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons

- The family of the deceased

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

N Meadows
H.M. Senior Coroner – Manchester City Area **29 July 2019**