

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO: Secretary of State for Health, Secretary of State for Education, the Health and Safety Executive (HSE), the Chief Executive Greater Manchester Mental Health NHS Foundation Trust (GMMH) and the Chief Executive of Cheshire and Wirral Partnership NHS Foundation Trust (CWP)</p>
1	<p>CORONER</p> <p>I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 13th July 2018 I commenced an investigation into the death of Hannah Dolly Kaur Bharaj. The investigation concluded on the 2nd July 2019 and the conclusion was one of suicide. The medical cause of death was 1a) Traumatic brain injury</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>In her first year at university, Hannah Bharaj had anxiety and depression. There was an early opportunity to address her mental health when she did seek help on one occasion in her first year. She found the focus on her academic performance rather than her difficulties adjusting to her grief unhelpful and did not seek further help that academic year.</p> <p>From May 2017, she began to use withholding food from herself to help her manage and provide a feeling of control. By September 2017 she had significantly deteriorated and sought further help from the University and GP. The GP identified it was likely she had an eating disorder. Hannah took a leave of absence from University and returned home. She was seen by the Bolton Eating Disorder Team, she was diagnosed as having atypical anorexia and depression. Attempts to treat her in the community were unsuccessful and her BMI was 13.6 kg/m² by 4th December 2017. On the 5th December 2017, she was admitted to the Eating Disorder Unit (EDU). She was a patient there until her discharge on the 22nd May 2018</p>

	<p>when her BMI was 17.3 kg/m². Formal psychology sessions had not started until 23rd March 2018 because the Eating Disorder Unit did not have a psychologist in post.</p> <p>Throughout her time in EDU Hannah expressed suicidal ideation which fluctuated. On the 22nd May 2018, she was discharged into the community. No discharge plan was sent to the GP. On the 25th May 2018 a close family member died. At the final psychology appointment on the 29th May 2018, she described specific methods she had considered to end her life including overdose. The barrier to that being insufficient medication. Her mental health had clearly deteriorated and her suicidal ideation increased. There was a failure to communicate the detail of this to her family or the prescribing GP. This probably contributed to Hannah taking, on the 31st May 2018, a large overdose of her medication prescribed by her GP who had not been notified of her suicide risk by the Eating Disorder Unit or been asked by the EDU to prescribe in a way that would reduce risk.</p> <p>Hannah was assessed by the RAID team, following the refusal of the Eating Disorder Unit Team to accept her back. A decision was made to place Hannah in an adult acute psychiatric bed.</p> <p>A local NHS bed was not available and she was placed at The Priory in Cheadle on the 7th June 2018. The Mental Health Trust did not appoint a Care Co-Ordinator until prompted by the Priory on the 13th June 2018. The Care Co-Ordinator did not engage effectively with Hannah, her family or The Priory.</p> <p>Hannah did not improve at The Priory. Her psychiatrist there identified that it was not the most appropriate place for her and wanted her to go to the EDU. The EDU took a different view. Hannah's weight did not improve. Her anorexic thoughts did not improve. The consequence of this was that her suicidal ideation increased as her feelings of hopelessness increased. The placement of her in a setting not equipped to effectively deal with her severe anorexia has probably contributed to her death. The Priory did not request her notes from the EDU, particularly her counselling notes and as a result, they were not fully sighted of the specifics of her previously expressed thoughts of suicide. As a result, the level of risk in her leaving the unit whilst her mental health was deteriorating was not fully assessed. This has probably contributed to her death.</p> <p>On the 12th July 2018, Hannah went to the first floor cafe at John Lewis, Cheadle with her parents. The height of the balustrade was such that once she was on a table she was able to jump from the café to the ground floor suffering catastrophic injuries. She died at Salford Royal Hospital on 13th July 2018 from her injuries.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p>

The MATTERS OF CONCERN are as follows:-

1. The inquest heard that discharge planning including communication with GPs and families around risk was not effective. Key information was not shared with the GP or the family particularly when care moved back to the family;
2. There was no clear evidence of consideration of discharge medication and risk around prescribing of medication post discharge from the EDU. As a result Hannah was prescribed a month's supply of medication;
3. The suitability of acute mental health beds for young adults and lack of alternative provision The inquest heard that Hannah went to an acute adult psychiatric bed because the EDU felt that it was the wrong environment for her and there was no other alternative. The inquest heard that there were concerns regarding the placement of a young adult in such a setting and how frightening it was to her;
4. Communication with private providers by NHS trusts once mental health trusts have placed individuals in private settings. During the time that Hannah was placed at the Priory the mental health trust who placed her did not have any discussion with Hannah, her family or the Priory regarding the placement. A care coordinator had been allocated by the Trust once requested by the Priory but no care coordination had taken place;
5. The expectations around information sharing with private providers and the expectation on private providers contracted by the NHS to seek information. The Priory did not request any notes from the EDU about Hannah. As a result they were unaware of detailed information held by the Trust regarding previously expressed suicidal ideation;
6. Understanding and communication by the Priory about the change in risk level when Hannah moved from a secure environment to periods of time outside the unit in the care of her family;
7. The inquest was told by the clinical lead for Eating Disorders of the high risk of Eating Disorders in high achieving students on courses such as medicine. In such cases, the inquest was told universities need to be alert to early signs of anxiety that risk leading to eating disorders developing. As part of this understanding by universities the inquest was told of the need to recognise early signs of mental health issues and listen carefully from an early stage. The skill set/training of academics in welfare roles in relation to mental health was described as key and specific work with Eating Disorder services and training of those involved in welfare programmes supporting students can be effective;
8. The guidance in relation to the height of glass balustrades where items such as tables, in cafes open to the public including children and other vulnerable people, are placed in close proximity to the glass. The

	<p>glass balustrade in John Lewis was at a height that accorded with the required standard but by simply climbing onto the table that was adjacent to the balustrade Hannah was able to easily go over the balustrade.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 18th September 2019. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely 1a) Hannah's parents 2) Stockport Metropolitan Borough Council 3) the Priory Hospital, Cheadle 4) John Lewis & Partners, who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>Alison Mutch HM Senior Coroner 24.07.2019</p> 