REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Chief Executive, Springfield Hospital, 61, Glenburnie Road, London. SW17 7DJ. The Chief Executive, NHS East Leicestershire and Rutland CCG, Pen Lloyd Building, County Hall, Glenfield, Leicester. LE3 8TB Chief Executive, NHS England, Fosse House, 6, Smith Way, Grove Park, Enderby, Leicestershire. LE19 1 SX.
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** Between 19th November 2019 and 28th November 2019, evidence was heard touching the death of **Rebecca Jane Hursey.** Rebecca had died at St George's Hospital on 4th May 2018, following an aspirin overdose taken whilst detained under Section 3 of the Mental Health Act at Springfield Hospital. She was 39 years old at the time of her death. The Jury made the following findings: **Medical Cause of Death** I (a) Multi-organ failure (b) Salicylate poisoning

II Mixed personality disorder, Eating disorder non-specified, Significant self-harm

How, when, where and in what circumstances Rebecca came by her death:

Rebecca Hursey died on 4/5/2018 at 00:54 at CITU St George's Hospital of multi-organ failure and salicylate poisoning, caused by a self-administered overdose of aspirin, which was discovered at approx. 5:15 am on 3/5/2018.

At the time of her death she was diagnosed with mixed and other personality disorders, eating disorder non specified, chronic microcytic anaemia and significant self-harm.

She was receiving care on the Avalon Ward which is an eating disorder unit at Springfield Hospital, and she was subject to Sec 3 of the Mental Health Act. She was suffering with severe and enduring mental illness. The overdose occurred while Rebecca was under level 3 observation. Overnight observations between 2/5/2018 and 3/5/2018 were not recorded in line with the Observation and Engagement policy. Observations and searches were unable to mitigate her risk of self-harm and suicide. Extensive and so far, unsuccessful searches had been undertaken for alternative placements to provide her with required treatment and to more safely manage her risk of self-harm.
An "impasse" in treatment for her diagnosis had arisen but day-to-day treatment continued.
Rebecca's illness was such that her state of mind was very delicately balanced: she was easily and deeply distressed by clinical treatments and by proposed changes to her support arrangements.

Proceeding her death these matters impacted her state of mind:
Treatment with iron infusion under restraint.
Impending loss of her psychotherapist.
Postponement, as she perceived it, of the meeting to plan her future on 30/4/2018.
Possible negative impact of multiple psychiatric assessments.
Feeling 2in limbo" in relation to discharge.

With regards to matters that possibly contributed to her death:
Handover system in place on the 2/5/2018 should have allowed the allocated nurse to familiarise themselves with written records by the psychotherapist.
If the suicidality captured in the written records of the psychotherapist had been noted, further opinion would have been sought and extra vigilance would have put in place.
The prolonged and unsuccessful search for an alternative placement that started in February 2014 until the time of her death impacted the state of Rebecca's mind and effectiveness of her treatment.

With regards to matters which may probably have caused or contributed to her death:
Her inability to accept the diagnosis and accept treatment appropriately.
Her underlying medical frailty with anaemia and heart failure.
Her overall high risk of suicidality and self-harm.

In the time leading up to her death, Avalon was an inappropriate placement for Rebecca to provide treatment consistent with her diagnosis. Avalon was an inappropriate place to manage her high risk of suicidality and self-harm.

Conclusion of the Jury as to the death:

Rebecca Jane Hursey took her own life whilst suffering with severe and enduring mental illness.

4	Extensive evidence was taken in court. In summary, of relevance to this report: On the day that Rebecca is thought to have taken the overdose that took her life she had been recognised by the psychologist as strongly and actively suicidal. This was recorded in the notes, but not passed on verbally by him to the nurse in charge. Handover was verbal between shifts and this increased suicidal risk was not appreciated by the allocated nurse such that extra support for Rebecca was not considered at the material time. Rebecca had been a patient on Avalon from June 2013. Discharge was considered from early 2014 but no suitable alternative placement was found for her prior to her death in May 2018. Her complexity and suicidality was well documented from early on in her psychiatric care, as far back as 2002 when she was living in Leicester, but with the lack of somewhere suitable to go, Avalon was left in an untenable position of having no choice but to provide in-patient care for Rebecca, when it was clearly recognised that the ward could not manage her suicidality, nor provide suitable treatment for her. She had been referred to Avalon from Leicester based services, but they found no placement in their area, where she still had a residential address, for her to return to.
5	**Concerns of the Coroner:** 1. That staff handovers be led by examination of the clinical record such that recent progress can be assessed especially in relation to risk management and care plans amended accordingly. 2. That practitioners who recognise increase in suicidal risk of a patient should pass this on verbally to the nurse on charge of the ward or the nurse allocated to the patient. 3. That NHS England consider a system of introducing deadlines for alternative placements to be found for such patients, so that they must be found in a timely fashion. 4. That placements for patients with high risk of self-harm, such as Rebecca are prioritised such that safer placements are found within a timely fashion. 5. That bespoke placements are considered early in the discharge process for complex patients. 6. That consideration be given to the "sharing" of such complex and high-risk patients between units early on the in-patient stay to help provide the patient with more suitable care and share the stress of caring for such unwell patients on staff and other patients. One way this could be done would be to consider a network arrangement between different units to avoid the risk of clinical silos between the different sections of the mental health services and encourage a more wholistic approach to service provision.
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 consider and respond to the concerns relevant to their own organisation.
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 : [redacted] 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	**9th March 2020**  **Professor Fiona J Wilcox** **HM Senior Coroner Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED** **Honorary Professor QMUL School of Medicine and Dentistry**