ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Executive, Oxleas NHS Trust, Pinewood House Pinewood Place, Kent, DA2 7WG**
1	**CORONER** I am Dr Julian Morris, assistant coroner, for the coroner area of Inner London South
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 16.7.2019 I commenced an investigation into the death of CLAIRE LILLEY, aged 38. The investigation concluded at the end of the inquest on 30 November 2020. The conclusion of the inquest, before a jury, was a narrative conclusion which, in summary, was as follows: Claire's medical cause of death was: 1a Hypoxic Brain Injury 1b Hanging. Claire died as a result of injuries sustained by hanging herself. While the main contributing factor leading to her hanging was her mental illness, on the ward, relevant information was diffuse and there was no central formulation of the most pertinent information relevant to risk. This became especially relevant when several members of ward staff were on leave and there was insufficient management cover to review risk.
4	**CIRCUMSTANCES OF THE DEATH** Claire was detained undersection 3 of the Mental Health Act and admitted to Avery Ward on 22 October 2018, via the Queen Elizabeth Hospital following a significant overdose. During her admission she was diagnosed with a severe depression with psychotic symptoms in November 2018 and an additional diagnosis of generalised anxiety disorder in January 2019. She commenced various stages of ward leave in 2018 from accompanied to unescorted Section 17 overnight leave to her home. The status of that home leave and the anxieties she felt on leave varied. Claire gave a report to ward staff that although there were

	difficult times, overall the outcome was positive. [redacted] (Claire's mother) considered that certainly by the end of January/ early February 2019, those visits were not positive, resulting in increased anxiety for Claire. There was no direct contact or proactively sought feedback, by staff, certainly after the 6 February. On the 6th, [redacted] attended the ward and fed back her increasingly anxious views of home leave. A review on the 6th would, in the opinion of the appointed expert, have assisted in assessing her and was a missed opportunity. It was also confirmed that Claire's risk assessment was not discussed with [redacted] and there was no centralised document reviewing her risk – 'no formulation of that risk'. On 12 February, whilst on Section 17 overnight leave, Claire hung herself at home. She was found by her mother. Despite further measures, she sadly did not survive.
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** are as follows. – (1) Individuals who are the subject of detainment under the Mental Health Act are risk assessed at numerous times. For those that are on Section 17 home leave, they are additionally assessed prior to leaving the ward on each occasion. In addition, risks are also reviewed on the regular multi-disciplinary ward rounds. (2) However, such assessments are not centralised in any one place – there is no central formulation. Reviews by any clinician would have to cover 3 or 4 different entries by way of example: the risk assessment page, the MDT notes, the psychology entries (although they, per se, do not enter risks assessments). (3) The Court's expert confirmed that such a centralisation/ formulation (supported by the Route Cause Analysis report), would assist in reviewing an individual's risk and allowing ward staff to see the wider input in one place. (4) Training has been implemented by the Trust to assist staff in formulating risk, a process that was in place at the time of Claire's death. However, there is no central repository/formulation of the outcomes of those assessments. Different teams continue to use different tools; there is no stand-alone document. (5) Consideration should therefore be given to the creation of a centralised, formulated, risk document to be entered upon by all clinicians irrespective of their own speciality.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe the Oxleas NHS Foundation Trust 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,
	However, given the forthcoming Christmas and New Year Period, together with the increasing pressures of Covid-19 I set the return date of Monday 1 March 2021. This maty be extended upon request. 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] (Claire's mother). I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**11.12.2020** **Dr Julian Morris**