M. E. Voisin
Her Majesty's Senior Coroner
Area of Avon

8th July 2021 [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Avon and Wiltshire Mental Health Partnership NHS Trust and Minister for Patient Safety, Suicide Prevention and Mental Health**
1	**CORONER** I am M E Voisin Senior Coroner for **Area of Avon**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 21/08/2019 I commenced an investigation into the death of Maria STANCLIFFE-COOK. The investigation concluded at the end of the inquest. Box 3 of the record of inquest recorded the following: "Maria Stancliffe-Cook died on 1st August 2019 at [redacted] Highbury Villas, Cotham, Bristol. She had intentionally taken her own life with the use of helium causing asphyxiation. She had been assessed by the mental health team on 26th July 2019 and her risk had been downgraded from high to medium. She had a telephone call on 28th July 2019 which did not meet the standard; there was no assessment or plan to manage her risk undertaken at this time." The conclusion was: suicide contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Maria had a history of poor mental health over many years which resulted in a referral to the mental health team in January 2018. On 18th December 2018 Maria was admitted to A&E at Bristol Royal Infirmary having tried to end her life by using helium, and was referred to crisis team who later discharged her back to the care of her GP. On 23rd January 2019 her GP said that Maria told her that she'd ordered another helium kit, she denied any thoughts and was referred to the mental health team. From then until the events in July there are various appointments with the mental health team, her GP and her therapist. On 12th June 2019 there was a meeting with a number of those caring for Maria the notes say

	" we expressed our worry with Maria that with the method which she had considered in the past her ongoing social isolation and the sense that it is unlikely she would ask for help from others she would be a high risk of completed suicide if she attempted again. Her lack of protective factors beyond her investment in her studies was also discussed " Her care coordinator [redacted], was present and she said in her evidence that was read, "We were concerned about the ongoing risk of completed suicide given she continued to be in possession of a helium bottle, the risk was not considered to have changed since my first meeting with her when the risk to self was recorded as high". By 26th July 2019 things significantly changed. She reported to her therapist and GP both who knew her well that she was having active suicidal thoughts. She had told them both that she'd tried to use the helium cylinder but it failed so ordered another one; she also said that she'd been researching high buildings. Her therapist was extremely concerned and said that that this felt like she had a high intention to complete suicide. He reported this to the mental health team. Her GP said that this was a big change; Maria told her that her suicidal thoughts had got worse and they were difficult to dismiss. Her GP referred her to the mental health team explaining her concerns. Maria was seen that evening by two members of the mental health team neither of whom had met her before. They assessed her and decided to downgrade her risk from high to medium. On 28th July 2019 as planned one of the them telephoned Maria, this was Maria's last contact with anyone from the mental health team the call and the note making lasted around 3 minutes, she said that Maria told her she was ok. Sadly on 1st August 2019 – Maria was found dead by police after flat mates became concerned for her. That week she was also supposed to have an appointment with a care coordinator but that had not been arranged.
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 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. – The trust have themselves admitted the failures reflected in an independent report they commissioned after the death, that report said "we would not expect a patients level of risk to be downgraded from high … to medium immediately following a suicide attempt"; In addition I heard evidence in relation to the assessment on the 26th July 2019 when the risk was downgraded from high to medium. I listened very carefully to the steps that the Trust has taken to make changes following this death and I am pleased that a number of changes have taken place. I raised my concern about the downgrading of risk from high to medium in this case by two members of the team that had no previous dealings with Maria. Maria was well known to the trust and her own care coordinator said "We were concerned about the ongoing risk of completed suicide given she continued to be in possession of a helium bottle, the risk was not considered to have changed since my first meeting with her when the risk to self was recorded as high". That was a reference to a multidisciplinary meeting which took place a matter of weeks before her death. I was told that risk is dynamic and that professionals assess risk at the time and that it can go up and down. I was also told that there are lots of assessments by staff that do not know patients. That said there is a concern that there is a risk of future death - is it right that the risk of a patient, who is well known to the trust, with a care coordinator who knew her well, is downgraded without any check put in place.
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe you 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 3rd September 2021. 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 – the family. 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	08/07/2021 Signature M E Voisin Senior Coroner **Area of Avon**

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