Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

The Rt Hon Sajid Javid (MP) - Secretary of State for Health and Social Care

1 CORONER

I am Tom OSBORNE, Senior Coroner for the area of Milton Keynes

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 11th June 2019 I commenced an investigation into the death of Brooke MARTIN aged 19. The investigation concluded at the end of the inquest on 01 July 2021. The conclusion of the inquest was a Narrative Conclusion as follows:

> *She took her own life, whilst suffering from a mental illness, namely Emotionally Unstable Personality Disorder*

Her cause of death was:

I a Hanging

4 CIRCUMSTANCES OF THE DEATH AS RECORD BY THE JURY

> *Brooke Martin was a patient at Isla House, Chadwick Lodge, Milton Keynes and was detained under the Mental Health Act. She was admitted on 15th April 2019 and had been diagnosed with Emotionally Unstable Personality Disorder and Autism Spectrum Disorder; she initially failed to engage and was violent to staff and self-harming. By the middle of May 2019 she had made progress. On 5th June 2019 she was found with a ligature around her neck, which was suspended from the door of her room. Following this incident consideration should have been given to a formal risk assessment to include consideration of her level of observation. The details of the incident should have been fully disclosed to the MDT meeting on 6th June and consideration given to increasing the level of observation. The incident should also have been discussed and disclosed to all members of staff caring for her. On 10th June 2019 Brooke Martin was found secretly fiddling with a bedsheet on two occasions by two different members of staff at approximately 22.50 and 22.56 hours. The bedsheet should have been removed and examined, that would have shown that a section of the sheet had been torn off. This would and should have resulted in a full risk assessment and search of her room, that would have resulted in an increase in her level of observations to 1:1 observations. Brooke Martin, if constantly observed or other safety measures put in place would not have been able to tie the ligature that caused her death and would not therefore have died on 11th June 2019. She was found hanging in her room at approximately 23.00, CPR was commenced and she was taken to Milton Keynes University Hospital where she died on 11th June 2019.*

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

During the course of the evidence it was explained to me that it had not been possible to access the notes and records from an out of area hospital because not all the health providers were using "System One". It is a major concern that the various systems used throughout the NHS are not compatible with each other and it is not always possible for each healthcare provider to access the notes and records of the patient.

This situation should be reviewed to see how access across the NHS can be gained to patient records when required. I was told by one senior clinician that when a patient is referred to his specialist mental health unit it is often the case, that is 9 times out of 10, he does not receive all the information of the patient's history. This would not be the case if he had direct access to the records.

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.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 27th August 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 of Brooke Martin
- Elysium Health Care
- Surrey and Borders NHS Foundation Trust
- CQC

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

Tom OSBORNE
Senior Coroner for
Milton Keynes
Dated: 02 July 2021