REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) Medical Director, North West Boroughs Healthcare NHS Foundation Trust**
1	**CORONER** I am, Rachel Galloway, Assistant Coroner, for the Coroner Area of Manchester West
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 the 1st October 2018 an investigation was commenced into the death of Lauren Victoria Finch, aged 23 years, born 31st December 1994. The investigation concluded at the end of the Inquest on the 11th October 2019. The Medical Cause of Death was: 1a Hypoxic Brain Injury 1b Hanging The conclusion at the jury at the inquest was: Suicide
4	**CIRCUMSTANCES OF THE DEATH** 1. Lauren Finch was 23 years of age at the time of her death on the 24th September 2018. Since March 2018 she had had a significant number of admissions to Atherleigh Park Hospital, both as an informal Patient and as a Patient detained under the Mental Health Act 1983. She had a diagnosis of Emotionally Unstable Personality Disorder (EUPD) and also displayed depressive symptoms. 2. During the 6-month period prior to her death, there were occasions when Police had had to intervene and take Lauren to hospital, using their powers under s 136 of the Mental Health Act. On one occasion, Lauren had to be pulled down from the 9th story of a multi-story car park by Police. On another, she was found running in traffic on a main road. 3. We heard evidence that Lauren experienced thoughts of suicide and self-harm all of the time. However, there were periods when these thoughts would become more intrusive and more difficult for Lauren to ignore. Lauren had described hearing voices, telling her to end her own life.

4. In September 2018, Lauren was admitted again to Westleigh Ward at Atherelgh Park Hospital following an attempt to end her own life. On the 16th September 2016 Lauren absconded from the Ward. She was found by Police and brought back to Atherleigh Park Hospital. Lauren reported that she had been assaulted by Police following her return to the Ward and was recorded by staff as being very tearful and upset. On the morning of the 17th September 2018, Lauren's observations were reduced from 10-minute observations to 30-minute observations without any assessment taking place or discussion with her.

5. On the evening of the 17th September 2016, Lauren made a ligature from a bed sheet and suspended herself from her bedroom door. Staff had difficulties accessing her room (staff reported that the anti barricade system did not work). Upon entering her room, staff commenced basic life support and an ambulance was called. Lauren was taken to Royal Bolton Hospital but had suffered a significant brain injury and sadly passed away a week later on the 24th September 2018.

6. I heard the inquest, sitting with a Jury. The Jury concluded as follows:

7. Lauren Finch was found deceased in her room on Westleigh Ward at Atherleigh Park Hospital at approximately 21.20 hours on the 17th September 2018. She had used a bedsheet to form a ligature and suspend herself from the bedroom door. She had last been seen at approximately 21.05 hours

8. Lauren Finch was a patient on the ward, having been detained under the Mental Health Act on the 14th September 201. Attempts were made by staff to revive Lauren and an ambulance was called. She was taken to the Royal Bolton Hospital where it was confirmed that she had suffered significant brain damage. Her condition declined, leading to her death at the Royal Bolton Hospital on the 24th September 2018.

9. Further, the jury found:

   Probably causes of Lauren's death:

   1. The assessment of the risks of suicide on the 16th and 17th September 2018 were not properly assessed.
   2. Observation levels on the 17th September 2018 were not correct.
   3. The circumstances of Lauren absconding from Westleigh Ward on the 16th September, which led to
   4. An impact on Lauren's state of mind, following the police involvement in Lilford Park on the 16th September 2018.
   5. Lack of suicide risk review at Atherleigh Park.

      Possible causes of Lauren's death:

      1. The cycle of admissions and discharges from Hospital.
      2. Quality of observations.
      3. The lack of risk assessment of suicide and self harm.
      4. Failure of the anti barricade system, all at Atherleigh Park.

   There was a delay in accessing DBT (Dialectical Behavioural Therapy) for Lauren but this did not contribute to her death.

5 **CORONER'S CONCERNS**

During 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. During the inquest, evidence was heard that: 1. Nursing staff and Health Care Assistants on Westleigh Ward at Atherleigh Park Hospital were carrying out (and continue to carry out) observations of patients at precise intervals (for example, if a patient is on half-hourly observations, staff explained that they would aim to carry out observations at 10.00 am, 10.30 a.m., 11 am etc.). Further, all records showed that the timings of observations were at precise intervals. This is not in accordance with the Trust's policy of observations (which confirms that observations should be irregular but within the (e.g. 30 minute) window. The reason for this policy is clearly to avoid a situation whereby a patient can predict when they will next be observed (and offer an opportunity for the patient to take action to harm herself during that period of time). 2. The Deputy Ward Manager on Westleigh Ward at Atherleigh Park Hospital confirmed that she did not and still does not check that observations by staff are being carried out in accordance with the Trust policy, despite accepting that this was her role when the nurse in charge of a shift. Further, the Deputy Manager of Westleigh Ward did not understand the Policy and thought that observations were to be carried out at regular intervals (as referred to above). 3. The Trust carried out an investigation following the death of Lauren. It was of concern that the lead investigator (who gave evidence at the inquest) did not understand the Observation Policy and suggested that observations should be carried out at irregular intervals (which was correct) but then gave an example of 10 minute observations being carried out at: 10 am, 10.08 am, 10.20 am (which is clearly not in accordance with the Policy). The interval should never exceed the 10 minute period (and there is 12 minutes between 10.08 am and 10.20 am). 4. There were examples in the records of nursing staff putting in entries 24 hours after the event had occurred. Whilst it is accepted that nursing staff may, on occasion, need to wait some time before marking an entry into the clinical record, a period of 24 hours when dealing with patients at risk of self-harm and suicide means that relevant information is potentially not available to staff on the next shift.
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 16th December 2019. I, the assistant 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:

	(1) [redacted] Sharples, Bolton. (2) HC One - [redacted] Managing Director, HC-One, Southgate House, Archer Street, Darlington DL3 6AH (3) CQC (North) – [redacted] Inspector, Care Quality Commission (North, Adult Social Care, Manchester. 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 assistant coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Dated 21st October 2019**
	Signed: **Rachel Galloway** **HM Assistant Coroner** **Manchester West**