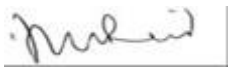
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Chief Executive, Herefordshire & Worcestershire Health and Care NHS Trust
1	**CORONER** I am David Donald William REID, HM Senior Coroner for Worcestershire.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 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 [the details below are fictional]** On 31 March 2020 I commenced an investigation into the death of Emily Jane CALDICOTT. The investigation concluded at the end of the inquest. The conclusion of the inquest was as follows: *"Emily Caldicott died as a result of tying a ligature around her neck. It is not possible to determine what her intention was at the time she did this.* *Please see questionnaire:* *QUESTIONNAIRE* *1.* *(a) At any point on the evening of 21 March 2020 did Emily lack capacity to make a decision about accepting Lorazepam medication?* *YES* *(b) If YES, did staff on Holt Ward carry out an adequate assessment of Emily's capacity at that point?* *NO* *2. If NO to Question 1(b):* *(a) did a failure adequately to assess Emily's capacity to make that decision probably cause or contribute to her death on 23 March 2020?* *YES* *(b) If NO or CANNOT SAY to Question 2(a), did a failure adequately to assess Emily's capacity to make that decision possibly cause or contribute to her death on 23 March 2020? YES/NO/CANNOT SAY* *3. On the evening of 21 March 2020 should staff on Holt Ward have administered IM Lorazepam to Emily 'under best interests'?* *Please note: if your answer to Question 1(b) was YES, you must answer this question NO, and not answer Question 4.* *YES* *4. If YES to Question 3:* *(a) did a failure to administer IM Lorazepam that evening probably cause or contribute to Emily's death on 23 March 2020?* *YES*

	(b) if NO or CANNOT SAY to Question 4(a), did a failure to administer IM Lorazepam that evening possibly cause or contribute to Emily's death on 23 March 2020? *YES/NO/CANNOT SAY* *5. Following the first ligature incident on the evening of 21 March 2020, should staff on Holt Ward have removed the [redacted] which Emily had used to make that ligature?* *YES* *6. If YES to Question 5:* *(a) did their failure to remove the [redacted] probably cause or contribute to Emily's death on 23 March 2020?* *CANNOT SAY* *(b) if NO or CANNOT SAY to Question 6(a), did their failure to remove the [redacted] possibly cause or contribute to Emily's death on 23 March 2020?* *YES* *Neglect* *If, but only if, you have answered YES to any or all of Questions 2(a), 4(a) or 6(a), you must also consider whether or not that particular failure by ward staff amounted to neglect. In order to do so, please first read and follow paragraphs 23-26 in the document 'Legal Directions (2)'. Once you have done so, please answer the following question:* *7. Was Emily's death contributed to by neglect?* *YES"*
4	**CIRCUMSTANCES OF THE DEATH** On 19th March 2020 Emily Jane Caldicott was admitted to Worcestershire Royal Hospital as a voluntary informal inpatient, in order to seek treatment, following an overdose of her medication. Emily had a background of significant mental health issues that stemmed from childhood sexual abuse and suffered from Emotionally Unstable Personality Disorder. On 21st March 2020 Emily was found unresponsive in her room on Holt Ward, Newtown Hospital, Worcester after tying a ligature around her neck, shortly after being detained under the Mental Health Act. She was then moved to Worcestershire Royal Hospital, where she died on 23rd March 2020 from pneumonia and cerebral anoxia due to the application of a ligature.
5	**<u>CORONER'S CONCERNS</u>** 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. – (1) By their conclusion expressed above, the jury were satisfied that on the evening of 21.3.20, when Emily tied the ligature which resulted in her death, staff on Holt Ward, Newtown Hospital, Worcester failed to carry out an adequate assessment of Emily's capacity to make a decision about taking Lorazepam to reduce her extreme anxiety and distress, and had they done so, they would have found that she lacked capacity in that regard, and would have administered an intramuscular injection of Lorazepam "in best interests"; (2) In the note which she made about these events on Care Notes, dated 22.3.20, staff nurse MM recorded as follows:

	"I offered her Oral Lorazepam, but she refused, however [Deputy Ward Manager] stated unable to give IM Lorazepam due to her being an informal patient and had already had IM administered under best interest on 19.3.20. On the balance of probability, Emily had capacity to understand that she was informal and that we could not administer medication under MAPA therefore team decided that IM should wait for further guidance from medic following his assessment for section 5.2." (3) In her evidence, staff nurse [redacted] denied that this was the test which was applied when deciding whether or not to give IM Lorazepam to Emily, but was unable to explain why she had recorded otherwise in the Care Notes, and why she had not corrected herself when making her statement for the inquest only 2 weeks after the incident, save to say that she had been distressed by what had happened. (4) In her evidence, Deputy Ward Manager [redacted] said that the reason she had not administered IM Lorazepam to Emily was because she had assessed her capacity to make a decision about such medication during an incident outside the nurses' office about an hour before the fatal ligature, and had concluded that she did have capacity to refuse it. She said that she had not formally assessed Emily's capacity thereafter because she did not think Emily required Lorazepam. She said that staff nurse [redacted] had recorded the test she applied wrongly in the Care Notes, because she may not have understood what she ([redacted]) was saying. (5) By their conclusion, the jury found that if an adequate assessment of Emily's capacity had taken place, she would have been given IM Lorazepam "in best interests", that this would have quickly relieved her anxiety and distress, and that her death would probably have been prevented. (6) Although staff on Holt Ward were undoubtedly having to deal with a very difficult situation in this case, I am concerned that if a such a decision has to be made in similar circumstances in the future, staff may not apply the correct test under the Mental Capacity Act 2005, and there is therefore a risk of future deaths occurring.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as Chief Executive of Herefordshire & Worcestershire Health and Care NHS 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, namely by **18 May 2022.** 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: GT Stewart Solicitors and Advocates (legal representatives of [redacted], Emily's father); [redacted] (Emily's mother). 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	**23 March 2022**  **David REID** **HM Senior Coroner for Worcestershire**