ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

1	**CORONER** I am Catherine McKenna, Assistant Coroner, for the Coroner area of Greater Manchester North
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 3rd December 2013, the Senior Coroner commenced an investigation into the death of Derek Hawkins, aged 49. The investigation concluded at the end of the inquest on 23rd September 2014. The conclusion of the inquest was 'Derek Hawkins took his own life by self-applied ligature on 24th November 2013. His death was contributed to by failures in communication, a lack of clarity around leave arrangements and by the fact that an assessment of his level of risk had not been undertaken following a disclosure of suicidal intent on 22nd November 2013.' The medical cause of death was 1a) Death by Hanging.
4	**CIRCUMSTANCES OF THE DEATH** Derek Hawkins had first been diagnosed with Bi-polar Disorder in 1991. He suffered a relapse of his condition in September 2013. Due to a concern about the persistence, fluctuation and increase in his suicidal thoughts and the fact that his response to home treatment had stalled, Derek was admitted to Northside ward on 4th November 2013 for the purpose of reassessment and treatment. Evidence from the Consultant Psychiatrist who had known Derek since 1992 was that this episode of illness was different to previous episodes in that, as well as an abnormally low mood, Derek may have been experiencing delusionary beliefs. Whilst this feature appeared to have resolved by the time that Derek was admitted to Northside, the Consultant's evidence was that there is a degree of unpredictability with Bi-polar Disorder and it is possible for a sufferer to experience psychotic symptoms consistently. Derek was granted escorted leave on 10 November 2013. He was subsequently granted unescorted leave limited to hospital grounds on 15 November 2013. Alterations were being made to Derek's medication at this time and a replacement mood stabiliser was introduced on 15 November and subsequently titrated upwards. Derek attended a Breakfast Club run by the Occupational Therapy team on 14 and 21 November. Evidence from the Occupational Therapist (OT) was that she noted a significant deterioration in Derek's presentation on 21 November. Her evidence was that there was evidence of paranoia and Derek's concentration was impacted. The following

	day (22 November) Derek approached the OT and informed her that he was going to hang himself 'as soon as possible.' The OT's evidence was that she relayed this information to one nurse and also spoke to a second nurse about the need for Derek to have 1:1 time that day. The OT made a written note of her contact with Derek in the nursing notes and highlighted her entry with an asterix and by writing 'OT input' in the margin of the notes. The nurse who attempted to have 1:1 time with Derek that evening did not read the OT's entry and her evidence was that because it was marked 'OT input,' she assumed that the entry related to Derek's level of functioning rather than suicidal risk. Derek's Care Plan was reviewed the following morning (23 November) by his Named Nurse. Her evidence was that Derek was sleeping at the time that she reviewed his Care Plan. Consequently, she did not have any 1:1 time with Derek that day. Derek left Northside ward unescorted at 10:30am on 24 November. None of the staff appreciated that his unescorted leave was limited to the hospital grounds. The police were notified that he was missing after his wife attended the ward at 1pm to collect him. Derek's body was found hanging in a derelict building near to the hospital grounds at 9:25pm that evening. I am assured by the Trust that actions have been taken to remedy the failings in this case which related to leave arrangements, communication and record keeping.
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. – (1) The Risk Assessment tool currently in use relies on an individual practitioner's subjective assessment and description of risk factors. The tool does not provide a means of objectively rating risk factors and means that less experienced practitioners may fail to recognise or identify an increase in risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 25 November 2014. 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, [redacted] and Chief Constable of Greater Manchester Police. 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	**[DATE]** 30/09/2014	**[SIGNED BY CORONER]** C M McKenna