REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

This report is made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

ASHLEY CORIN DE WINTER PONSONBY (deceased)

Recipients

This report is being set to:

- The family of the deceased
- Chief Coroner for England and Wales
- Rt Hon Mr Jeremy Hunt MP – Secretary of State for Health
- [redacted] Police and Crime Commissioner for Greater Manchester
- Sir Peter Fahy – Chief Constable, Greater Manchester Police
- Ms Michele Moran – Chief Executive, MHSC
- [redacted] Medical Director, MHSC
- Manchester North, Central and South Clinical Commissioning Groups

Copied for interest to:

- INQUEST
- Mind
- Coroners Society of England and Wales

Coroner

I am Nigel Sharman Meadows, H. M.Senior Coroner for the area of Manchester City.

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.

Investigation and Inquest

On 6th July 2012 I commenced an investigation into the death of Ashley Ponsonby, aged 32. The investigation concluded at the end of the inquest on 5th June 2014.
The cause of death was found to be:

1a Amphetamine and paramethoxyamphetamine toxicity

The conclusion of the inquest was as follows:

Narrative conclusion:

Ashley was a detained patient under the Mental Health Act Section 3 on Acacia Ward as a dual diagnosis patient. He was admitted in November 2011. On 3rd July he was able to inject illicit drugs. The support worker and the Nurse in charge were concerned about his welfare, therefore the SHO was called at about 10pm. The SHO advised to omit 10pm medication and he would come as soon as possible.

From approximately 6am Ashley deteriorated, which prompted the Nurse in charge to recall the SHO, who arrived promptly. Ashley's presentation continued to deteriorate; 999 was called at 7.22am.

The SHO researched the treatment of drug overdose and displayed material relating to that on the computer screen. This was prior to Ashley leaving the ward in the ambulance. However the SHO did not mention Naloxone, nor did the Nurse suggest using Naloxone.

The ambulance arrived at 7.46am. Ashley left Acacia at 8.01am in the ambulance and arrived at A&E at 8.02am. Despite the efforts of ambulance and A&E staff, Ashley sadly passed away. Ashley died as an unintended consequence of a deliberate human act of injecting illicit drugs.

1. Was Ashley subject to a regime of 15 minute observations initiated by the Nurse in charge of the ward and completed alternately between herself and another female support worker?
Answer: No

2. After the locum SHO doctor saw and assessed Ashley at about midnight, what form frequency and type of observations did he intend to initiate as part of his plan?
Answer: To take basic observations (BP, pulse, temp, UDS) at the Nurse's discretion, if the patient is awake.

3. Did the locum SHO doctor appropriately and adequately communicate that to the Nurse in charge?
Answer: No

4. Did the locum SHO doctor mention to the nurse in charge of the ward the medication known as Naloxone after his first assessment of Ashley?
Answer: No

5. Did the locum SHO doctor research the treatment of drug overdose and display material relating to that on the computer screen in the office prior to Ashley leaving the ward with the ambulance service?
Answer: Yes

6. Did the locum SHO doctor, before the arrival of the crash team, comment to one of the nursing staff that he thought that Ashley was withdrawing from opiates (1) and that the nurse suggested using Naloxone (2)?
Answer (1): No
Answer (2): No

7. What factors, if any, do you find probably made a material contribution to the death?
* Poor communication of relevant information between SHO and Nurse
* Inadequate escalation of information, issues and problems
* Inadequate record-keeping, e.g. AMIGOS, physical observations, datex, risk assessment
* Failure of datex policy, its understanding and application
* Inadequate control of access to illicit drugs
* Unapparent training of staff in dual diagnosis, drugs/toxicity symptoms, and Trust policies and procedures
* Inadequate security systems in place
* Failure of Night Manager to fulfil their roles and responsibilities
* Reaction to medical emergency was inadequate
* An insufficiently safe and secure environment
* Failure to recognise toxicity
* Failure to recognise Ashley's deterioration overnight, and at an earlier stage, and act upon with urgency
* Culture of complacency regarding drugs

8. What factors, if any, do you find possibly made a material contribution to the death?
* Ward management was inadequate.
* Inadequate ward formation at the outset of Acacia
* Lack of reports to the police and Trust security
* Failure of teamwork; e.g. MDT and ward staff
* Failure of care plans; e.g. long term deterioration, medical assessment and review/progression
* Poor liaison with family and MDT; e.g. email
* Inadquate management regarding patients' access to illicit drugs by Registered Clinician Managers

* Search policy was too flimsy
* Inconsistent approach to mangement of leave by Registered Clinicians/Nursing Staff
* Failure to recognise Ashley's depression
* Inadequate staffing levels
* Poor equipment and facilities; e.g. oxygen equipment, maintenance, lack of bed in clinic

Circumstances of death

Ashley was born on 1st October 1979 and was 32 years of age at the date of his death. In his middle teenage years he started smoking cannabis. Over subsequent years he is reported to have consumed cannabis, but also took cocaine, amphetamines, ecstasy, ketamine, LSD and alcohol. He had started a university course but left partway through. He had no settled employment for a period of time. In or about 2007 he got a job as a Support Worker in a hostel dealing with people with drug and alcohol problems.

In 2008 he attended a music festival and took a cocktail of drugs. He was then noted to be expressing strange and delusional thoughts. His mother was very concerned about him. He had some initial contact with mental health services and had time off work. By 2009 his condition was deteriorating. He had a brief A&E admission and was subsequently started on antidepressant medication. The dose of this was subsequently increased and by late summer 2009, he was prescribed antipsychotic medication. That autumn he was leading a very chaotic lifestyle and his delusional thoughts re-emerged.

Thereafter he had various contacts with A&E departments as well as mental health units and was eventually detained under the Mental Health Act, which turned into a Section 3 detention in early March 2010. He remained a detained patient at Park House psychiatric unit from then until the date of his death.

Technically speaking, he absconded from the ward shortly after this final admission and was not returned by the police until some four weeks later. He was diagnosed as suffering from schizoaffective disorder and poly-substance misuse. He was reluctant to take oral medication and reportedly had no insight into his illness. He was then started on a depot medication which had to be changed. He was still suffering symptoms and was paranoid. Gradually his condition appeared to settle and he was granted unescorted leave from the ward. However, he returned in an intoxicated state and his leave was temporarily suspended.

His parents were anxious that his mental state was once again beginning to deteriorate. MHSC were making arrangements to create a rehabilitation ward that was to be known as Acacia at Park House. It was due to house a maximum of 20 patients, all of whom would be male, and be detained under the Mental Health Act. A significant proportion of these patients were known

as dual diagnosis. That means that they had a primary mental health disorder but also drug/alcohol misuse problems.

He was transferred to Acacia Ward in early November 2011 and remained a patient on that ward until his death. Some 80% of the patients on the ward were also dual diagnosis.

Over the whole period of his admission to that ward, he tested negative for drugs on about 25 occasions. He had refused to provide a urine drug screen (UDS) on about a similar number of occasions, but over several months, he tested positive by means of a UDS for illicit drugs on at least 9 occasions. The drugs in question included cocaine, cannabis and in particular amphetamines, which he predominantly abused.

The staff on the ward recognised the changing nature of his presentation when he had taken drugs. A pattern of behaviour was noted; in that he would be granted unescorted leave and then return either testing positive for illicit substances or displaying symptomology associated with being under the influence of illicit drugs. Subsequently he may admit taking drugs, or thereafter provide a positive UDS. His unescorted leave would be restricted for some days but then be reinstated. It was also noted that on occasion even when his unescorted leave was restricted, he still managed to access and ingest illicit drugs. There was significant concern that another identified patient on the ward was a potential drug supplier. Ashley's parents made contact with the ward in early 2012 to report their concern and the identity of the patient who was believed to be supplying drugs.

By April, Ashley's parents were increasingly concerned about his condition and what they regarded as easy access to illicit drugs, which when he took them antidoted his psychiatric medication and led to mini-relapses. They even wrote to his Responsible Clinician expressing their concerns in blunt terms.

On 8th June Ashley tested positive for cocaine and his unescorted leave was suspended, but reinstated on 18th June. On 28th June he tested positive again for amphetamines and his unescorted leave was suspended.

On the evening of 3rd July his Responsible Clinician was absent due to sickness, but he had not been informed of the recent further positive amphetamine test. There was a change of shift at about 9pm and staff recognised that his presentation was similar to that when he had tested positive and taken drugs in the past. Some vital signs were taken and this indicated that he was significantly tachycardic and also had an abnormal blood pressure. The psychiatric SHO doctor was contacted, who advised to omit the night-time medication and that he would attend as soon as possible. He arrived about an hour or so later and had a brief discussion with the nurse in charge before examining the patient on his own. His blood pressure had returned to within normal parameters but he was still tachycardic, but it was not possible to do a pupillary examination due to a malfunctioning torch.

The nurse in charge accepted that she did not mention specifically about Ashley's recent misuse of drugs, and in particular amphetamines. However, the SHO doctor did not review the recent medical records. If he had done, they would have shown his recent drug misuse history. However, the doctor did consider drug misuse to be a possible explanation for his presentation.

The jury found that the subsequent treatment plan initiated by the SHO doctor was that the nursing staff should take basic observations (blood pressure, pulse, temperature and UDS) at the nurse's discretion if the patient was awake. However, the doctor did not appropriately and adequately communicate that to the nurse in charge.

The nurse in charge had indicated that before the doctor arrived, she and a nursing assistant had initiated an increased level of 15 minute observations. The nursing assistant had told the court that this had been initiated after the doctor had attended and was in place until she left duty in the early hours of the morning. The jury found that Ashley was not subject to any regime of 15 minute observations.

Consequently, no physical vital signs observations were recorded for several hours, although his location was identified every hour. Up until 5am, his presentation remained similar to earlier in the shift. However, at about 6am, it was noted to be markedly different. He was shaking and was pale. He admitted feeling unwell and had difficulty in standing and was also sweating profusely. The nurse in charge was alerted and she contacted the SHO doctor who arrived within minutes. This must have been some time after 6.15 or 6.30am. Ashley was examined again and it was noted that he was tachycardic and had lower than normal oxygen saturations. It was clear that a 999 call was not made until 7.22am. The SHO doctor said in evidence that he broke off his examination after about 15 minutes or so in order that a UDS could be undertaken and he claimed to have instructed the nurse in charge to phone 999. She adamantly denied this and the jury were unable to determine factually which version of events they preferred.

At 7.15am, two new nurses attended to start the next shift and immediately noted Ashley's condition. The SHO doctor was apparently in the process of contacting the A&E department to advise them of the imminent arrival of Ashley. Unfortunately it took some minutes for an ambulance to arrive and it did so shortly after 7.40am. Just before this, Ashley's condition deteriorated further and he was placed on the floor from a seated position. Initially he was breathing, but then had a cardiac arrest. Prior to this, the crash team from the hospital had also been called and they arrived almost simultaneously. He was given immediate first aid and CPR was commenced. Within a few minutes, he was transported to the A&E department of the hospital, arriving shortly after 8am. Despite continued efforts to resuscitate him, these proved unsuccessful and he was pronounced dead at 8.29am.

Despite the nature of the ward and the fact that it would contain a high proportion of dual diagnosis patients, staff had not been trained in recognising

and dealing with the risks of physical harm arising from the use of illicit substances.

It had been suspected that another patient had been supplying controlled drugs to Ashley and others on the ward. The Trust Datix incident reporting system and the risk register were not used to record the instances of drug taking or the specific concern about this patient. The ward manager candidly accepted that it was not until the second day of the inquest hearing himself that he had recognised and seen the use and importance of utilising those procedures. The police had not been formally advised about the suspicions involving the patient and it was understood there was no agreed local Trust policy with the police or a wider one within the whole of Greater Manchester regarding police involvement on mental health wards. The court was told that the recently appointed local Police and Crime Commissioner had designated someone to consider this, but no formal draft policy had yet been finalised.

The jury was assisted in receiving evidence from an Accident and Emergency treatment expert, a mental health nursing expert, as well as a psychiatrist, completely independent of the Trust. The Trust itself had carried out a significant serious untoward incident investigation. The jury found that a number of factors had probably materially contributed to the death, as well as several which had possibly done so.

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. It is a matter of concern that any ward could be set up and operated involving the inherent risks of drug misuse by dual diagnosis patients without the staff having any training in recognising and dealing with the physical harm and risks arising from the use of illicit substances. The evidence from the independent psychiatrist was that this was an essential ingredient. Consequently, in rehabilitation wards or those with dual diagnosis patients where there is a risk of continuing drug misuse, the concern which arose was that without this, there was a risk of a future death arising. This has implications locally for the Trust, regionally and on a national basis.

2. There is a concern that the failure to use the Datix and Trust incident reporting policy, as well as the risk register (or other similar procedures available to other Mental Health Trusts), to identify the problem of drug supply and/or consumption, if unremedied may lead to a future death. It is a concern both locally for the Trust, regionally and nationally, that such procedures should be appropriately used so as to prevent a future death.

3. There was a concern that a lack of a coherent and mutually understood policy between the Mental Health Trust and the Police as to when they would become involved in illegal activity meant that neither the patients nor the staff had clarity on the position. Just because patients have mental disorder, does not absolve them of all legal responsibilities and indeed understanding and facing possible criminal consequences may be important in their overall clinical management and for the administration of justice. It was suggested that this was being considered by Greater Manchester Police and the local Police and Crime Commissioner, but no policy had yet been finalised. Once again, this has local, regional and national implications, and that the concern is without such policies being formulated and implemented, there is a continuing risk of future deaths which could be prevented.

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.

Your response

You are under a duty to respond to this report within 56 days of the date of this report, namely by 25th August 2014. 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.

Copies and publication

I have sent a copy of my report to the Chief Coroner and to Interested Persons. I have also sent it to organisations who may find it useful or of interest.

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.

N S Meadows **Date** 27th June 2014
H.M. Senior Coroner – Manchester City area