REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Iain Tulley - Chief Executive** **Avon & Wiltshire Mental Health NHS Trust** **Jenner House** **Langley Park Estate** **Chippenham** **Wiltshire** **SN15 1GG**
	CORONER I am M. E. Voisin, Senior Coroner, for the Area of Avon
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 2nd December 2014 I commenced an investigation into the death of **Simon Peter REYNOLDS**, aged **47**. The investigation concluded at the end of the inquest on 15th July 2015. The medical cause of death reached following a Jury inquest was as follows: 1a) Acute pneumonia 1b) Cachexia and chronic obstructive pulmonary disease. The conclusion of the Jury inquest was **"The conclusion of this jury is that as a consequence of choking on paper which led to cardiac arrest, Simon subsequently died due to acute pneumonia, cachexia and chronic obstructive pulmonary disease"**
4	**CIRCUMSTANCES OF THE DEATH** On 10th November 2014 Simon was admitted to Mason Unit at Southmead Hospital after he was detained under s136 of the Mental Health Act by the police. He was admitted to the unit at around 21:00 hours and by 21:20 hours he was found by the staff in the bathroom with his hand over his mouth and he appeared to be choking. He was taken to the Intensive Care Unit at Southmead Hospital but died on 21st November. Evidence was given that Simon was experiencing a psychotic episode with comments such as "he had bought the devils stone and lost" and that he thought "he was on a route to hell". There were times when Simon appeared to be fighting hallucinations. One of the police officers who escorted him to the unit and was present with him said that Simon honestly believed what he was saying he was completely distressed. During his admission he attempted to stab himself in the neck with a pen, which the staff then removed. He also had his shoes and laces removed when he told the staff he wanted to die and they had concerns about self-harm/suicide. Whilst left alone in his room Simon forced a fist sized ball of paper into his throat which caused him to choke. During his short admission he was on 10 minute observations.

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) I heard evidence that there is no documented risk assessment produced at the time of a service user's admission onto Mason Unit. I would ask that you review whether this is still appropriate. (2) During the investigation I heard evidence that the nurse in charge made no record on the computerised Rio notes in relation to the admission. I would ask that you look into the appropriateness of this. (3) I would also ask that you consider whether guidance or training ought to be provided to staff on how to set patient observation levels when being admitted onto Mason Unit; what factors to take into account when assessing a service users risk of suicide or self-harm and how to manage that risk appropriately and how to appropriately communicate that risk to other staff.
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 **21st September 2015**. 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 - and to the local safeguarding adult's board. 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	**24 July 2015** **M. E. Voisin** [redacted]