REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive** **Norfolk & Suffolk NHS Foundation Trust** **Fermoy Unit** **Queen Elizabeth Hospital** **Gayton Road, King's Lynn** **Norfolk, PE30 4ET** **2. Chief Executive** **Queen Elizabeth Hospital** **Gayton Road, King's Lynn** **Norfolk, PE30 4ET** **3. Chief Executive** **Norfolk & Norwich University Hospital** **Colney Lane, Norwich** **NR4 7UY** **4. Chief Executive** **James Paget University Hospital** **Lowestoft Road** **Gorleston, Great Yarmouth** **Norfolk, NR31 6LA**
1	**CORONER** I am JACQUELINE LAKE, Senior Coroner, for the coroner area of NORFOLK
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 16 July 2013, I commenced an investigation into the death of CHRISTOPHER JONATHAN HIGGINS, AGE 36 YEARS. The investigation concluded at the end of the inquest on 16 DECEMBER 2015. The conclusion of the inquest was Medical Cause of Death: 1a) Severe head injury with extradural haemorrhage (operated on) and Conclusion: Suicide
4	**CIRCUMSTANCES OF THE DEATH** On 23 December 2013 Mr Higgins became a voluntary patient at the Fermoy Unit. On 24 June 2013 Mr Higgins self-harmed resulting in a wound to his neck. He was taken to the Accident and Emergency Department, Queen Elizabeth Hospital, King's Lynn. Whilst being treated, Mr Higgins grabbed a pair of scissors and repeatedly stabbed himself in the chest. He was restrained. Mr Higgins received medication and was returned to the s136 Suite at the Fermoy Unit. Whilst there he was taken out for a cigarette and dived over the railings landing on the ground below, sustaining a head injury. Mr Higgins was taken to the Queen Elizabeth Hospital, King's Lynn and then transferred to Addenbrooke's Hospital where he died as a result of the head injury on 2 July 2013.

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) It became clear during evidence, that members of staff are not aware of what is required of them when they carry out Observations on a patient. This was particularly evident with regard to Observations to be carried out on a "two members of staff to one patient" basis. Areas of confusion include how staff are to engage with a patient, how close they are required to be with regard to the patient, i.e. at arm's length or within eyesight and how to record the information gained from the Observation. (2) The Escort Policy does not include information relating to the transfer of patients from one place to another (in this case from an Acute Hospital to the Fermoy Unit) when other services are involved, for instance the Police. In particular, Mr Higgins who had been acting in an unpredictable and paranoid manner, was put into a cage at the rear of the Police van with three Police Officers, with no Mental Health staff to accompany him. The evidence did not reveal that this had been considered by the Mental Health staff previously attending to Mr Higgins; (3) The safety of the environment where the incident took place, namely a disabled ramp with a railing along the edge and a concrete floor, had not been risk assessed prior to taking Mr Higgins outside for a cigarette. It is understood that since Mr Higgins' death the railing has been heightened. There was no evidence of a formal Risk Assessment having been undertaken since his death. Other ways of making the area safe are still under consideration. (4) There is no agreement in place between the NSFT and the Acute Hospital as to the best way to deal with patients subject to detention under the Mental Health Act who require assessment and treatment at A & E, as a result of which Mr Higgins, was required to wait over 2 hours in a busy, public area, having already self-harmed and shown signs of paranoia.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 February 2016. 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: [redacted] (parents) Norfolk County Council Norfolk Constabulary Cambridge Constabulary Department of Health Healthwatch Norfolk I have also sent it to CARE QUALITY COMMISION 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.
9	**24 December 2015** ..... **Jacqueline Lake** **Senior Coroner for Norfolk**