REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Dudley and Walsall Mental Health Partnership NHS Trust, Trafalgar House, 47 – 49 King Street, Dudley, West Midlands, DY2 8PS** **2. Care Quality Commission**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 the 29 April 2016, I commenced an investigation into the death of the late Mr Glen Jordan. The investigation concluded at the end of the jury inquest on 23 August 2016. The conclusion of the inquest was a short narrative conclusion: misadventure with failure as a rider to this conclusion. A failure in medical intervention contributed, namely a failure to respond to an obvious risk of self harm contributed. An example being the bag strap to being confiscated. Mr Jordan died from asphyxiation due to hanging at Bushey Fields Hospital, Dudley, West Midlands on the 24 April 2016. The cause of death was: 1a) Asphyxiation 1b) Hanging 1c). Depression
4	**CIRCUMSTANCES OF THE DEATH** 1. Glen Jordan worked as a part-time data engineer and lived with his father. He separated from his ex-partner around two years ago but remained in touch and they have a child from the relationship. 2. He had suffered with previous episodes of depression and around twelve months ago took an overdose of 90 antidepressant tablets and had exhibited thoughts of self-harm and taking his own life. 3. He contacted his GP in April 2016 and sought medical help because he was experiencing suicidal thoughts. 4. He was initially referred to Dorothy Pattison Hospital and then onwards to Bushey Fields Hospital in Dudley on the 20 April 2016 where he was admitted as an informal patient. 5. On initial assessment by the Consultant Psychiatrist at the Dorothy Pattison

	Hospital he was diagnosed as suffering from moderate to severe depression with underlying relationship difficulties. The Doctor concluded it was "was imperative to admit him to keep him safe and to assess his depression and consequently address his social and relational difficulties". 6. Mr Jordan agreed to informal admission to Hospital. 7. A further clinical assessment took place by the on call duty doctor at Bushey Fields Hospital on the 20 April 2016 where he was transferred to. On this occasion, the multidisciplinary risk assessment concluded his current risk was low for self-harm and suicide. He was subsequently placed on level one observation. 8. He was visited by his former partner during his admission in Hospital and a holdall bag with some of his belongings was given to him. The contents of the bag were checked by staff and he was allowed to keep the bag in his room. Attached to this bag was a strap. 9. Over the course of his stay from 20 April through to 24 April 2016, he seemed to be interacting with staff and involved in various activities including a cooking group. 10. On the 23 April 2016, he maintained a low profile and spent the majority of his time on the ward. 11. He was seen by the on call doctor to explore his request to leave the ward and to spend some time with ex-partner and children. He confirmed he still had thoughts of harming himself but no active intent or plan to act on these. 12. At around 2am on the morning of the 24 April 2016, he was discovered hanging with a ligature (bag strap from his holdall bag found in his room). 13. He was taken to Hospital and pronounced deceased shortly afterwards. 14. The Trust held an investigation and concluded: i) The root cause of the incident was found to be a spontaneous action undertaken by patient that was outside of the patient's assessed risk/presentation and noted to be out of context with their regular behaviour ii) No issues were identified for any care and service delivery issues and in terms of recommendations and lessons learned, none were identified. iii) In terms of contributory factors, the investigation concluded that the availability of a suitable item (the strap from his bag) to compete the action was a contributing factor. There was however no clinical indications prior to the incident occurring, that such an action was likely and the clinical decision not to remove this item from the patient's bag was appropriate and in line with recommended least restrictive principles.
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. Evidence emerged during the inquest that the holdall bag with the attached strap was left in his room after being checked by staff. There is a fine balance that needs to be reached in terms of removing personal items and allowing patients to keep their personal items within their room as per guidelines for least restrictive policies.
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. 1. You may wish to consider reviewing your policy/guidelines in respect of patient property that can be brought into Hospital where they potentially provide a ligature source.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 3 October 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; Family representative. 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	**7 September 2016** Z Siddique **Mr Z Siddique** **Senior Coroner** **Black Country Area**