REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Care Quality Commission** **2. [redacted], daughter of the Deceased** **3. Avon and Wiltshire Mental Health Partnership NHS Trust** **4. Chief Coroner**
1	**CORONER** I am Dr. Peter Harrowing, LLM, Assistant Coroner, for the coroner 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 6th April 2016 I commenced an investigation into the death of Mr. Martyn Watkins aged 65 years. The investigation concluded at the end of the inquest on 11th November 2016. The conclusion of the jury was that the medical cause of death was I(a) Hypoxic brain injury; I(b) Hanging, and their conclusion was that of: "Suicide - facilitated by access to means, resulting from inadequate checks to remove ligature risks from his person and a failure to identify fundamental risks in the environment".

4	**CIRCUMSTANCES OF THE DEATH** During December 2015 Mr. Watkins suffered a deterioration in his mental health related in part to concerns he had with the health of close members of his family and his own retirement from employment as an accountant. He came under the care of the mental health services and was seen by members of both the Primary Care Liaison Service (PCLS) and the Intensive Support Team (IST). Mr. Watkins had contact both by face-to-face visits at home and also telephone contact with members of those teams on a regular basis. The plan was to try and support Mr. Watkins and his family at home so as to facilitate his recovery. However, he developed suicidal ideation and required two brief hospital admissions one following an intentional overdose of medication. His family became increasingly concerned at the risk Mr. Watkins posed to himself from suicide such that they removed all medication from his home, including that of his wife, and gave him doses of his medication as required. However, the family were finding it extremely difficult to manage the situation and keep Mr. Watkins safe. There was no real improvement in his presentation and there were significant concerns regarding his thoughts of suicide. By March 2016 the family reported they were at their 'wits-end'. On 22nd March 2016 Mr. Watkins daughter contacted, via social media, the Associate Practitioner on Aspen Ward, Callington Road Hospital which is part of the Avon & Wiltshire Mental Health Partnership NHS Trust ('the Trust') in an attempt to seek any assistance to help her father. These two individuals knew of each other through a mutual third party. The Associate Practitioner contacted Mr. Watkins' daughter and offered to speak with a consultant psychiatrist on Aspen Ward. The Associate Practitioner duly spoke with the consultant psychiatrist on the morning of 23rd March 2016 who in turn agreed to provide a second opinion if appropriate. Mr. Watkins' daughter was contacted again that morning by the Associate Practitioner seeking further information. However, by this time a Mental Health Act (MHA) Assessment had been arranged and this was planned for that same day. On 23rd March 2016 the Associate Practitioner explained the situation to the Ward Manager of Aspen Ward who agreed that Mr. Watkins could be admitted to that ward if his admission and detention was required. The Ward Manager contacted the IST advising that Mr. Watkins could be admitted to Aspen Ward subject to a bed being available. The MHA assessment was undertaken as planned by the Approved Mental Health Professional (AMHP) and two consultant psychiatrists and it was determined that he needed to be admitted to hospital under s.2 Mental Health Act 1983. The Section 12 approved psychiatrist told the Inquest that Mr. Watkins was at high risk of suicide and at risk of impulsive acts. During the afternoon of the 23rd March 2016 the ward was advised that the second registered mental health nurse due to work the late shift that day was sick and as a result that shift would be staffed by only one Registered Nurse (herself undergoing her preceptorship) together with the Associate Practitioner, Health Care Assistants and a student nurse. Prior to the Ward Manager going off duty at around 17:30 hours the Registered Nurse advised the Ward Manager that she would not be able to accept any new admissions during her shift since she would be the only Registered Nurse on duty. Sometime later the Associate Practitioner advised the Registered Nurse that Mr. Watkins was going to be admitted to the ward and he arrived at around 20:20 hours. The Registered Nurse was unsure what had been agreed between the Associate Practitioner and the Ward Manager with regard to Mr. Watkins' admission to the ward. However, the Associate Practitioner advised that she was able to admit him to the ward.

	On his arrival on the ward Mr. Watkins' stated he wished to go directly to his room and he was taken there by the Associate Practitioner. The Registered Nurse told the Inquest that she did not see Mr. Watkins at all during her shift as she was mostly attending to duties in the office. The AMHP also attended Aspen Ward and saw the Registered Nurse but did not speak to the Associate Practitioner. Aspen Ward is a ward designed for older patients and Mr. Watkins was admitted to a room intended originally for those patients requiring palliative care. In the room, in addition to the service user's bed, was a fold up bed constructed of an aluminium frame and wooded slats, which was intended for use by a relative of the service user. This bed was fixed and located within a wooden cupboard and folded flat against the wall. The bed could be pulled down when required for use. The cupboard was believed to have been locked although no witness at the Inquest confirmed they had checked the cupboard was locked at the time. Some witnesses from the ward were unaware there was such a bed within this cupboard. The Associate Practitioner went through the admission procedure with Mr. Watkins. She told the Inquest that she went through his bag carefully noting its contents and removed some items she considered could be potentially used as a ligature. The Associate Practitioner, in evidence, told the court that she did not enquire of Mr. Watkins as to what items he had on his person nor did she carry out any search of Mr. Watkins for items which might have posed a risk to him. She told the court that she did not know he was wearing a belt and therefore Mr. Watkins retained his belt. Mr. Watkins was placed on 10-minute observations by the Associate Practitioner. Following the later incident the observation chart went missing and has not been found. Those witnesses, who had carried out some of the observations, who gave evidence at the Inquest confirmed they carried out their observations at the required times. During his time on Aspen Ward it appears Mr. Watkins remained fully clothed at all times. He was seen overnight to be sleeping on his bed and was fully clothed. Overnight he was seen by the duty doctor to be clerked on to the ward and for his medication to be prescribed. No physical examination was carried out at that time. The following morning, the 24th March 2016, Mr. Watkins was seen by the consultant psychiatrist who did not notice the belt. He was also seen by a ward doctor who conducted a physical examination including an abdominal examination. That doctor did not give evidence at the Inquest. One Healthcare Assistant (1) who carried out some of the 10-minute observations reported that Mr. Watkins would not speak and did not make eye contact. Another Health Care Assistant (2) was able to engage in some conversation with Mr. Watkins. At around 12:15 hours the Health Care Assistant (2) saw Mr. Watkins in his room inviting him to the dining room for lunch. Mr. Watkins declined and also did not wish to have any food in his room. Shortly after 13:00 hours Health Care Assistant (2) went to Mr. Watkins' room for a 10-minute observation. He saw the doors of the cupboard containing the bed open and Mr. Watkins hanging from his belt used as a ligature which had been secured to the top aluminium rail of the bed. He sounded the site-wide alarm and lowered Mr. Watkins to the floor. Other members of staff quickly attended and CPR was commenced. The paramedics and air ambulance were summoned. Mr. Watkins was unconsciousness and he was taken to Southmead Hospital, Bristol. Despite treatment on the Intensive Care Unit he never regained consciousness and died in hospital on 1st April 2016. The witnesses who attended the Inquest stated they had not seen Mr. Watkins wearing his belt. Police officers and CSI attended Aspen Ward. A police officer states he was shown the observation chart at that time by the Ward Manager and confirmed there were entries at the appropriate times. The doors of the cupboard containing the bed did not appear to have been forced. The police officers were satisfied there was no third party involvement in Mr. Watkins' hanging.

	During the course of the Inquest the evidence revealed that: 1. There was no documented discussion between teams of the purpose of admission and concerns about risk in the community. 2. The room used to accommodate Mr. Watkins was inappropriate and unsafe given his high risk suicide. 3. There had been no risk assessment of the cupboard and fold-up bed with respect to ensuring the cupboard was secure and the presence of ligature points. 4. On arrival on the ward the standard procedure for admission was not followed with no documentation of the admission by a registered professional. 5. No enquiries were made, and no proper search was made, of Mr. Watkins to ensure he had no items on his person which could pose a risk to him although items in his bag had been removed. 6. There was a lack of communication of the specific risks in the progress notes and 72-hour care plan created by the Associate Practitioner. 7. The risk of hanging was not considered as Mr. Watkin's had only expressed thoughts of taking an overdose before admission to hospital.
	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 care and treatment provided by the Trust to Mr. Watkins should be reviewed at the earliest opportunity in the light of the findings of the jury at the Inquest and the Trust's own internal management report and root cause analysis report. (2) The CQC should satisfy themselves that any and all deficiencies in the care provided to Mr. Watkins and generally on Aspen Ward have been identified and addressed. (3) The CQC should satisfy themselves that an appropriate timetable and action plan are in place to ensure any outstanding issues on Aspen Ward relating to the safe care and treatment of service users are addressed at the earliest opportunity. (4) The CQC should satisfy themselves that the arrangements and facilities for the provision of care and treatment of service users on Aspen Ward, now and in the future, are such as to ensure those service users can be provided with safe care and treatment.
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 9th January 2017. 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 [redacted] daughter of the deceased, and the Avon and Wiltshire Mental Health Partnership NHS Trust I shall send a copy of your response to Ms. Watkins and the Avon and Wiltshire Mental Health Partnership NHS Trust I have sent a copy of my report to the Chief Coroner. 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	**14th November 2016**  **Assistant Coroner**