REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, NHS Lothian, Scotland.** **2. Chief Coroner**
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 21 March 2017, I commenced an investigation into the death of the late Mr Melvin James and his sister, Ms Anne-Marie James. The investigation concluded at the end of the jury inquest on 24 August 2017. The conclusion of the inquest was a narrative conclusion: *"On the 07th March 2017, Melvin spent the evening smoking and drinking with his sister and mother. On the morning of the 08th March 2017 Melvin was displaying unusual behaviour. This resulted in the fatal stabbing of his sister Anne-Marie James.* *This was followed by multiple stabbings of his mother who managed to lock herself in the bathroom and call the police* *There were 2 confrontations with unarmed and firearm police who used the appropriate level of force in attempting to detain Melvin. At some point that morning Melvin inflicted multiple stab wounds to himself, which ultimately lead to his death at approximately 11.00.* *Regrettably there was a missed opportunity for the handover to discuss discharge by both the hospital staff and Melvin's family. Consequently there was no follow up care. There was a further missed opportunity on the inadequate documenting and recording of the conversations between the hospital staff and Melvin's family."* The cause of death was: 1a Multiple Stab Wounds
4	**CIRCUMSTANCES OF THE DEATH** i) Approximately six years prior to this incident, Mr James moved from Wolverhampton to Edinburgh. On 4 February 2017 Police officers in Edinburgh responded to reports of a male walking on a carriageway in the early hours of the morning. Both officers recalled that Mr James was displaying obvious mental health issues, believing that he, his family members and various public figures were Transformer characters trying to defend the world. ii) Due to these concerns, Mr James was taken to Royal Edinburgh Hospital.

He was not detained at any point by police and agreed to attend Hospital on a voluntary basis.

iii) Upon arrival at the Royal Edinburgh Hospital on 4 February 2017, Mr James presented as having altered perception and described significant psychotic symptoms. He reported having taken 'red pills', 'alien eggs' and reference was made to that he was 'Megatron' (Transformers character) and referred to other family members and public figures as other Transformers characters. He also stated that a 'dangerous clown' could brainwash him to 'kill or be killed'.

iv) He was formally detained initially for a 72 hour period. He was seen by various clinicians and Consultant Psychiatrist. They concluded that he had likely had some form of drug induced episode initially. During the initial admission, he went to the door of the ward where he spoke about the need to travel to see his mother in Wolverhampton. He could not really explain what his concerns about his mother were but he appeared to be worried about her safety. He did not accept reassurance or persuasion to stay in hospital and at this point he began to kick the door of the ward. He became aggressive towards the Nursing Staff and this led to him being detained under an Emergency Detention Order (a 72 hour detention order used in Scotland which authorises detention in hospital but not treatment).

v) He was restrained and given intramuscular medication. At this time Mr James was actually given 2mg of intramuscular Lorazepam, a Benzodiazepine medication which is commonly used to treat symptoms of anxiety. There was evidence of acute kidney injury from the blood test results and he was encouraged to drink larger volumes of fluid. There was no previous history of any mental health conditions.

vi) During his admission, his brother, [redacted] remained in contact with him and nursing staff. Blood tests revealed presence of opioids. His brother was told that he had a paranoid psychotic episode.

vii) Between the period, Monday 6th February and Friday 10th February Mr James' mental state showed a gradual and consistent improvement. His beliefs about being a transformer, his beliefs about world figures and his general level of disorganisation all improved significantly.

viii) On 10 February 2017 Mr James was discharged having been diagnosed with a drug induced psychosis and overall was considered a low level of risk on discharge and no further psychiatric follow up was planned.

ix) His brother [redacted] travelled to Edinburgh on 10 February 2017 to collect him. There was no one to meet or greet him from Hospital staff and there was no explanation or handover done and nobody explained what signs to look for in case of a relapse.

x) He was then taken to Wolverhampton to live with his mother, [redacted]. During the journey Mr James was still exhibiting delusional beliefs when talking to his brother.

xi) [redacted] recalled he was in contact with Mr James whilst he was living in Wolverhampton. He recalled there were a few occasions where Mr

	James said some things that were 'clearly not reality' and suggested he was still suffering with some mental health problems. [redacted] recalled telling Mr James to visit his doctor, as he was not taking any medication to help him, but Mr James maintained that he did not need to. xii) [redacted] stated that when Mr James arrived at her address in February he 'seemed ok, he looked fine and was his normal happy self'. She recalled that in the days leading up to this incident on the 8 March, Melvin kept talking about going on holiday to Jamaica and said he had put a deposit down on a holiday, though she thought he was joking as he did not have the money to afford such an expensive holiday. She explained that during the evening before and morning of this incident Melvin was in a strange mood and was very quiet. He was smoking and drinking a lot and there appeared to be something wrong with him. xiii) On the morning of 8 March 2017 officers from West Midlands Police attended [redacted]' address following reports that Mr James had stabbed his mother and sister. xiv) Initially unarmed officers attended and Mr James was tasered. This had little impact and the unarmed officers retreated fearing for their own safety. He then went back into his flat and firearms officers then intervened and he was further tasered and restrained. xv) It was only after being detained, did it become apparent the extent of stab wound injuries he sustained. Sadly, Mr James and his sister, Ms Anne-Marie James were both pronounced deceased a short time later. Their mother sustained extensive injuries and after extensive treatment in Hospital she recovered.
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 by the time of his discharge on Friday 10th February 2017 and as far as the Hospital were concerned, they recorded he showed no evidence of mental illness. However, the Clinician who dealt with the discharge confirmed that he wasn't aware of the conversation he had with his brother on the way to Wolverhampton where Mr James was still talking about his delusions including creatures transforming. Significantly, during the inquest he accepted, had he known this he would have formed the view that he was still unwell. 2. He also accepted that there was a missed opportunity in communication and information sharing and it was regrettable they didn't speak to the family and explain what symptoms to look out for in case of relapse. 3. Evidence also emerged during the inquest that after discharge, there was no formal referral or contact made with Mental Health services or his General Practitioner based in the Wolverhampton area. There was no evidence of any aftercare being delivered after discharge back into the community.

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. Given the inadequate discharge process, you may wish to consider re-visiting your procedures and systems arising from this incident to ensure that this is not replicated and appropriate lessons are learned.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 6 November 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 the Chief Coroner and to the following Interested Persons; Family. 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	**8 September 2017** **Mr Zafar Siddique** **Senior Coroner** **Black Country Area**