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. Chief Executive - Oxleas NHS Foundation Trust.** **2. Secretary of State for Health, Department of Health.** **3. The Chief Coroner.**
1	**CORONER** I am Christopher Williams an assistant coroner, for the coroner area of Inner London South (Southwark Coroners Court).
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. http://www.legislation.gov.uk/uksi/2013/1629/regulation/28/made and http://www.legislation.gov.uk/uksi/2013/1629/regulation/29/made
3	**INVESTIGATION and INQUEST** An investigation into the death of **John William Sloan** commenced on the 22/8/2017. The investigation concluded at the end of the inquest on **16th January 2018**. The conclusion of the inquest was that the medical cause of death was 1(a) hanging. The short form conclusion was "Suicide".
4	**CIRCUMSTANCES OF THE DEATH** 1) On the 16/8/2017 the Mr Sloan hanged himself whilst he was alone inside his home address. He was found by neighbours, hanging from a ceiling beam in his loft, having used an electrical cable as a ligature. 2) At the time of his death he had been under the care of the local Mental Health Team, of Oxleas NHS Foundation Trust ("Oxleas"), since June 2017 due to suffering from anxiety, depression, sleeplessness and suicidal ideation. During his initial contact with the mental health service the antidepressants he was taking caused hyponatraemia (low blood sodium level) and were discontinued. 3) His last face to face contact with the mental health team, before he died, was on the 8/8/17 when he appeared angry that his situation was not improving following the administration of a new antidepressant (Trazdone) and also feeling stigmatized by his mental-health condition. 4) During this contact on the 8/8/17 he was not asked about whether he was experiencing suicidal ideas or plans. 5) On the 11/8/17 his daughter phoned the Mental Health Team and disclosed that the deceased had blamed himself for her suffering a miscarriage as a result of his mental illness. That information was not recorded by the community psychiatric nurse who took the call and no action was taken by the Mental Health Team as a result. 6) At the end of the inquest I indicated to the representative for Oxleas, and [redacted] Mr Sloan's daughter, that I was considering making a regulation 28 report but before doing so I would be assisted by written representation from Oxleas and [redacted]

7) I indicated that I had two concerns:

1. That on 8/8/17 the Care Co-ordinator employed by Oxleas did not ask Mr Sloan whether he was experiencing suicidal thoughts during a face to face meeting.

2. That on the 11/8/2017 the same Care Co-ordinator had not recorded the information provided by [redacted] occasioning no further action being taken by the Mental Health Team.

8) I gave Oxleas 14 and days to respond to my proposal and a further 14 days for [redacted] to provide written observations on the Oxleas response.

9) I received a response from Oxleas, on the 26/1/2018 that dealt with the two issues I had raised by creating an addendum to the Trust's original Root Cause Analysis report. The response stated:

"Following the inquest touching the death of Mr Sloan on 16 January 2018, the addendum below has been added to this report.

At the inquest two issues that had not previously been known to the panel were raised:

1. *On 8 August 2016, the Care Co-ordinator did not ask Mr Sloan whether he was experiencing suicidal thoughts. This was the last face-to-face contact with Mr Sloan and this question should have been asked to ascertain Mr Sloan's mental state. In his evidence, the Care Co-Ordinator acknowledged that he should have asked about suicidal thoughts.*

2. *On 11 August 2016, Mr Sloan's daughter spoke to the Care Co-Ordinator on the telephone but this was not documented in the clinical records. The Care Co-Ordinator accepted that the phone call took place but could only recall a conversation around medication. In her evidence, Mr Sloan's daughter said that she told the Care Co-Ordinator that her father felt guilty about her miscarriage and said 'So I am a baby murderer now'. The Care Co-Ordinator did not recall this but stated that this would have caused him some concern and he would have visited Mr Sloan. He accepted that he should have documented the conversation.*

The panel were not able to interview the Care Co-Ordinator as he did not return to work following the incident and has subsequently retired.

<u>Recommendations:</u>

1. *Service users with a recent history of suicidal thoughts to be asked about this at each contact.*

2. *All contact with service users and their carers to be documented in the clinical record."*

10) The response from Oxleas also enclosed a table identifying actions specific actions that were being taken. These were:

1. With regard to not exploring suicidal ideation with a service user (as occurred on the 8/8/17) the desired outcome is for: Staff to be aware if a service user is experiencing suicidal thoughts so a plan can be put in place to support the service user. In order to achieve this the following actions are being taken: 1a. Random audit from the team's caseload to be completed to ascertain whether suicidality has been explored at most recent contact with a service user, and 1b. To discuss the same in a team meeting.

2. With regard to not documenting the concerns of a service user's carer (as occurred on 11/8/17) the desired outcome is for all staff to be aware of the concerns of a service user's carer by way of the following actions: 2a. To be raised in team meeting and 2b. To be raised at an Embedded Learning Event with staff across the trust.

11) The response I received from [redacted] does not directly engage with the answers provided by Oxleas. However [redacted] has carefully set out wider concerns than those I had indicated I was prepared to deal with at the end of the inquest hearing and in my view raised issues of public policy and health care strategy coming from a wider evidential pool than the evidence I considered during the inquest. Whilst important matters were raised they were not matters which had been fully explored within the narrower scope of the inquest

12) I am therefore only minded to report upon the two issues I identified at the end of the inquest based on the evidence I heard and the factual findings I identified in the record of inquest.

5 **CORONER'S CONCERNS**

From the evidence before me at the inquest and written representations I have received after the inquest there are matters giving rise to concern. In my opinion there is a risk that future deaths could 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) With regard to the contact on the 8/8/17 I am concerned that the deceased was not asked whether he was experiencing suicidal ideas or had suicide plans. Whilst it is a matter of speculation as to whether he would have disclosed suicidal plans or ideas I consider that this was an error in the management of the deceased's mental health condition and was a missed opportunity to put in place supportive measures if such thoughts had been disclosed.

(2) With regard to the contact with the Care co-ordinator on the 11/8/17 the failure to record the concerns of Mr Sloan's daughter was a fundamental omission which also represented a missed opportunity to put in place supportive measures which may have prevented the suicide.

Whilst it is reassuring that Oxleas are proactively addressing the two concerns I have raised I consider that it is still important to publicly record my concerns by reporting the matter to the Minister for Health and the Chief Coroner. This because it provides the opportunity for other mental health care providers throughout England and Wales to learn lessons from the circumstances surrounding this particular death and to consider putting in place the same, or similar measures, to those deployed by Oxleas NHS Foundation Trust to reduce the risk of recurrence.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations have the power to take the following action: - **Oxleas NHS Foundation Trust** should indicate the outcome of the proposed actions identified in the addendum to the Root Cause Analysis report outlining what the findings of the auditing exercise were; the actions proposed in the meetings identified in the addendum report; and an outline of what was delivered in the embedded learning event.
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 April 2018**. I, the coroner, may extend the period. Your responses 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 who may find it useful or of interest: **Secretary of State for Health, Department of Health.** 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	**12th February 2018** **Christopher Williams – Assistant Coroner**