In re. the death of RYAN JAMES VOUT.

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. Jeremy Hunt MP, Secretary of State for Health;** **2. Amber Rudd MP, Secretary of State for the Home Department;** **3. Craig Guildford, Chief Constable, Nottinghamshire Police;** **4. [redacted], Police and Crime Commissioner, Nottinghamshire;** **5. [redacted], Leader, Nottinghamshire County Council;** **6. [redacted], Service Director, Mid Notts, Adult Social Care & Health Department, Nottinghamshire County Council, County Hall, West Bridgford, Nottingham, NG2 7QP** **7. Ruth Hawkins, Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust;** **8. [redacted], Clinical Quality Manager, NHS England;** **9. Julian Mark, Executive Medical Director, Yorkshire Ambulance Service NHS Trust;**
1	**CORONER** I am Andrew McNamara, Assistant Coroner, for the coronial area of Nottinghamshire.
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 17 October 2016 an Inquest was opened into the death of Ryan James Vout. That was concluded at the end of the inquest on 3 November 2017. The conclusion of the jury after the inquest was: Medical cause of death: *Single stab wound to chest* How, when and where the deceased came by his death: *Whilst suffering from un-medicated paranoid schizophrenia and during an attempt by police officers to exercise a warrant obtained under section 135 Mental Health Act 1983, Ryan Vout stabbed himself in the left side of the chest with a knife. The knife penetrated the left lung and the left ventricle of the heart.* *Ryan then removed the knife at the request of a police officer.* *Despite emergency first aid and hospital treatment Ryan died at 2.28 p.m. on 10 August 2016 at Kingsmill Hospital, Sutton in Ashfield.* Conclusion of the jury as to death: *Ryan Vout died as a result of a self-inflicted stab wound administered whilst suffering from un-medicated paranoid schizophrenia.*
4	**CIRCUMSTANCES OF THE DEATH** Since about the end of 2006/beginning of 2007, Ryan had been diagnosed with what [redacted], Community Consultant Psychiatrist, described as relapsing and remitting paranoid schizophrenia accompanied by persecutory ideas about the police; auditory hallucinations; grandiose thoughts and speech. His condition tended to be well controlled when he maintained his drug regimen. During

	the intervening 9 ½ years prior to Ryan's death his symptoms fluctuated requiring occasional, sometimes extensive, periods as an inpatient. Immediately before his discharge on 1 August 2016, Ryan had been an inpatient at Millbrook Hospital, Nottinghamshire since 5 May 2016. Concerns were quickly raised by family and community mental health professionals that Ryan's mental health had deteriorated in the 7 or 8 days or so since his discharge from Millbrook Hospital. Most likely, (on the basis of evidence of the absence of any trace of prescribed anti-psychotic medication (here risperidone) in the post mortem toxicological samples), Ryan had stopped taking his oral medication. On 9 August 2016, [redacted] (Approved Mental Health Practitioner (AMHP)) began the process of obtaining a warrant under s.135 (1) MHA 1983, informed local police of his intention to do so and made arrangements to meet officers so that the warrant could be executed. The warrant was obtained in the morning of 10 August 2016. PB informed the police and arrangements made to meet at the address at which it was believed Ryan would be found. At around 1pm on [redacted] and [redacted] and [redacted] met at the relevant address and prepared to exercise the warrant. By reason of some information exchange, but in the absence of formal risk assessment, all were aware that Ryan had expressed views that he would take his own life if he saw a police officer (attempt to 'section' him) and that knives might be secreted at the property. Body worn camera footage and audio obtained by [redacted] revealed that, as the officers made their way into the premises and announced their arrival, Ryan expressed fear at their presence and then retreated into an upstairs bedroom where he plunged a kitchen knife into his chest which, as it transpired, damaged his left lung and punctured the left ventricle. Emergency First Aid and hospitalisation could not save Ryan. From call out following [redacted] radio request, the EMAS emergency ambulance took six minutes to arrive at the address. In the course of the evidence it became clear that it was not possible to 'pre-book' an ambulance as the most appropriate means of transport for a potential psychiatric patient. The evidence also revealed that the competing emergency calls made upon the local ambulance provider (EMAS) meant that such pre-arrangement was incompatible with delivery of an emergency service. Although ambulances could be arranged once the AMHP and police officers arrived at the location where the warrant was to be exercised that request would not be treated as an emergency or a high priority (in the absence of threat to life). All interested parties, especially the police, expressed frustration that within Nottinghamshire there is no alternative, dedicated, fully equipped ambulance, capable of being pre-booked for attendances such as the one in this case for the execution of s.135 MHA 1983 warrants (or detention under s136 MHA 1983). Additionally, prior to Ryan's discharge from hospital, no meeting took place between the treating psychiatrist and the community psychiatrist; Ryan's care co-ordinator had moved jobs and not been replaced; and Ryan's family were not informed of the discharge. Although evidence was heard to say that the Trust now has a full complement of community psychiatric nurses, it was not clear whether a formal discharge protocol existed or has since been brought into being so that patients are not discharged until contact between professionals and family has been established.
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) The lack of a co-ordinated discharge from in-patient psychiatric care into the community, in particular the failure of appropriate professionals from hospital and community to liaise and for family to be informed as a pre-requisite for

	discharge; (2) The inability to pre-arrange attendance of an ambulance when police officers exercise a s.135 (1) MHA Act 1983 warrant; (3) The lack of formality to the 'briefing' or risk assessment exercise before officers enter premises with a view to exercising a s.135 (1) MHA Act 1983 warrant.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation have 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 27 December 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 Parties/Persons: 1. [redacted] 2. [redacted] 3. Craig Guildford, Chief Constable, Nottinghamshire Police 4. Julie Hall, Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust 5. [redacted], Leader, Nottinghamshire County Council 6. [redacted], Independent Police Complaint Commission. 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	**6 November 2017** **Andrew McNamara**