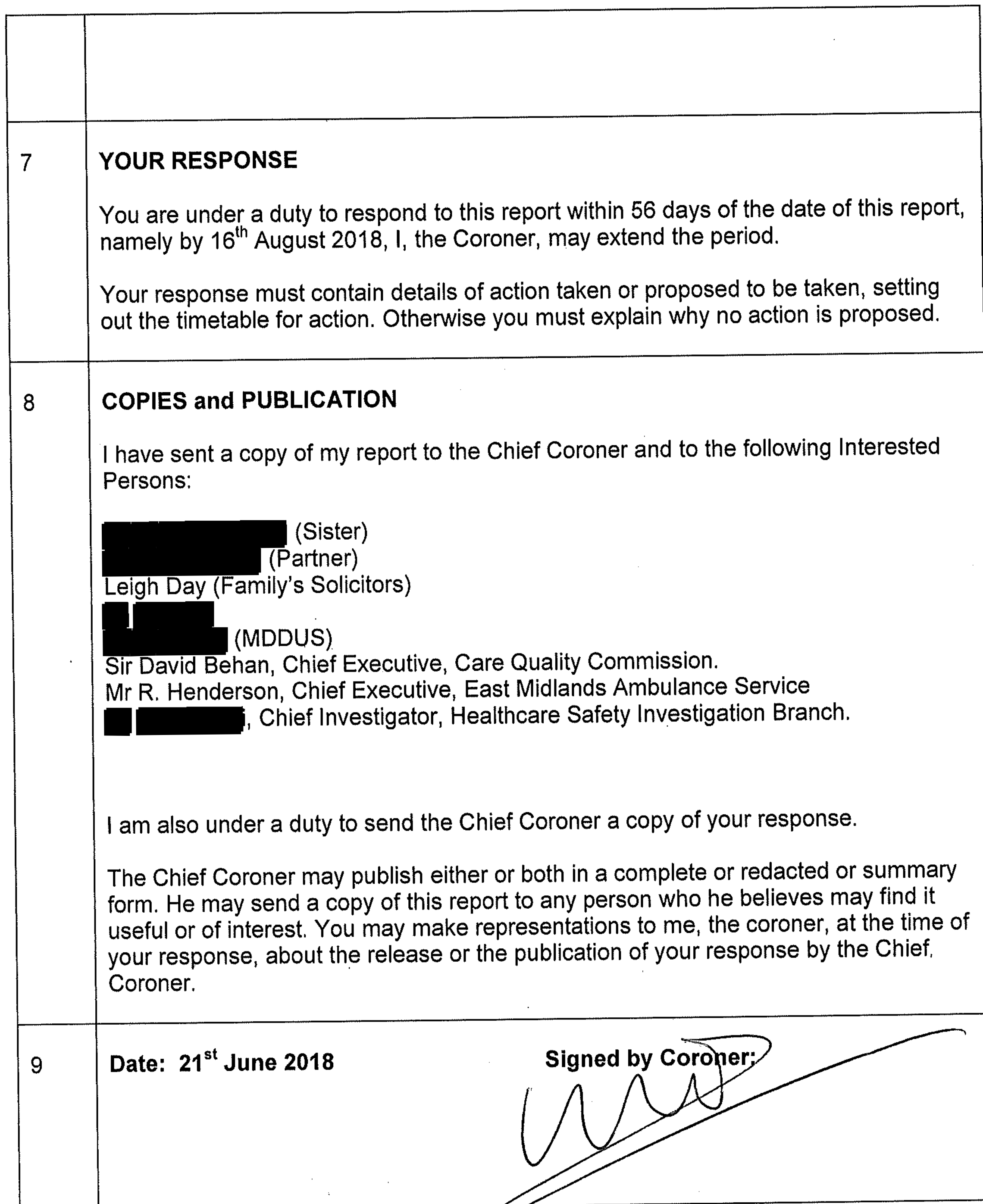
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Dr P. Miller, Chief Executive, Leicestershire Partnership NHS Trust.** **Mr J. Adler, Chief Executive, University Hospitals Leicester NHS Trust.**
1	**CORONER** I am Lydia Brown Assistant Coroner, for the area of Leicester City and Leicestershire South
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 3rd February 2017 I commenced an investigation into the death of John Charles Hazlewood. The Inquest concluded on 13 June 2018. Cause of death: **Inhalation of white spirit and injury of the right ulnar artery.**
4	**CIRCUMSTANCES OF THE DEATH** John died 31 January 2017 at [redacted], Wigston, Leicestershire. Narrative conclusion. John presented to mental health services during January 2017 with increased anxiety and initially was appropriately assessed by his community psychiatric Consultant and then by a MHP in the urgent care centre at Leicester emergency department. Despite denying any intention of self-harm, 2 days later he was admitted via the emergency department to the Leicester Royal Infirmary after a mixed overdose of alcohol and cardiac medications. John self-discharged later the same day. No mental health assessment was carried out and this was a missed opportunity to re-evaluate his ongoing care in the light of the material changes in his presentation. No notes were made in the psychiatric record and this caused community safety netting to fail.

	John barricaded himself into his garage, significantly self-harmed using hand tools available to him and consumed a large amount of white spirit. He died, notwithstanding emergency assistance, as a result of his actions. He intended to take his own life and understood the consequences of his actions.
5	**CORONER'S CONCERNS** 1. The court heard that the on call Dr for psychiatry did not have remote access to Mr Hazlewood's medical records and this prevented her from being informed of his significant psychiatric history, and furthermore prevented her from writing a note of her discussions regarding his request to self-discharge. Therefore the knowledge that he had presented again via ED with a serious overdose was not available to his Consultant so an opportunity was missed to escalate his care. Many of the on call team do have remote access and the Leicester Partnership Trust are asked to consider this issue for all relevant clinicians in order to avoid future difficulties of communication. 2. Mr Hazlewood's partner was repeatedly expressed to be his main or only protective factor from self-harm. She was not approached for information regarding his overdose, or her concerns regarding his escalating behavior and this missed an opportunity for the fuller picture to be captured when considering care planning and mental health assessment. This is an issue that I have raised with the Leicester Partnership Trust before in the matter of [redacted] and it appears that carers/families are still not being routinely involved in the care of mentally unwell patients. This can create intolerable pressures upon families and leads to poor outcomes such as in these 2 cases. LPT are urged to consider how this matter can be embedded in training and practice. 3. The court was assured that the induction process had been changed to improve knowledge regarding on call procedures and availability of medical record access. No information was available, via audit, of whether this amended process is successful. LPT should ensure that the outcomes of their welcome changes are being effectively monitored to ensure clinicians have appropriate training and understanding given the frequent rotations of staff and the importance of the on call system being robust and reliable. 4. University Hospitals of Leicester staff, both Dr and nurse gave evidence to the Court that they had not received any training in self harm, notwithstanding they were both highly likely to encounter patients attending with self-inflicted injuries regularly in both the Emergency Department and in the Acute Medical Admissions unit. With self-harm statistics sadly soaring, this is an increasing matter of concern. It is not appropriate to rely on "buying in" psychiatric services and leaving front line staff treating patients with no basic knowledge of this complex area and potential triggers. Training would empower the staff and is likely to assist them both in caring for the patients but also the carers/families who may need advice and support. NICE guidelines CG16 is clear that training should be provided to all staff who may encounter such patients and UHL should therefore reconsider this matter.
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.



7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 16th August 2018, 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: [REDACTED] (Sister) [REDACTED] (Partner) Leigh Day (Family's Solicitors) [REDACTED] [REDACTED] (MDDUS) Sir David Behan, Chief Executive, Care Quality Commission. Mr R. Henderson, Chief Executive, East Midlands Ambulance Service [REDACTED], Chief Investigator, Healthcare Safety Investigation Branch. 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	**Date: 21st June 2018** **Signed by Coroner:**