REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Black Country NHS Foundation Trust** **2. For their information only- Care Quality Commission**
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 19 March 2018, I commenced an investigation into the death of Mr Colin Johns. The investigation concluded at the end of the inquest on 14 June 2018. The conclusion of the inquest was a short narrative conclusion of: Suicide contributed to by neglect. The cause of death was: 1a Multi-Organ Failure b Paracetamol Overdose 11 Congestive Cardiac Failure, Severe Chronic Obstructive Pulmonary Disease, Ischaemic Heart Disease
4	**CIRCUMSTANCES OF THE DEATH** i) Mr Johns was a 71 year old man who lived alone at home and was first in contact with the local mental health services in 2006 and had a history of low mood and alcohol dependency. He had also previously been admitted to Penn Hospital following an overdose of paracetamol and alcohol. ii) He was admitted to the A and E department at New Cross Hospital on the 11 March 2018 at 16:29 hours. iii) He had been drinking and told staff he felt suicidal and wanted to self-harm and be admitted to Penn Hospital for psychiatric review. At the time of admission, he had multiple health problems including cancer of the throat and had a feeding tube in place. iv) He was referred to the mental health liaison team, and when sober assessed by the mental health nurse. v) No immediate bed was available for him to be admitted to hospital and he was given sedatives and discharged home on the morning of the 12 March at 2.27am. His follow up care was handed over to the home treatment team

(HTT).

vi) A nurse from the HTT attended the following day and found him collapsed at home. Police gained entry and then there was a two hour delay before paramedics arrived. Mr Johns told the nurse he had taken an overdose of co-codamol tablets at 3am shortly after discharge from hospital.

vii) He was then re-admitted to the same hospital and despite an antidote being given his condition deteriorated rapidly and he died at 18:34pm.

viii) There were failures to accurately take his full history as part of the risk assessment and the mental health team staff were unaware of the fact he had attempted to strangle/suffocate himself whilst in the A and E department.

ix) In addition he had tried to gain access to the drugs trolley whilst in the A and E department.

x) An internal investigation report concluded that the root causes were:

Whilst there was no one root cause identified through the RCA investigation process, this investigation highlighted multiple contributory factors that were considered within the investigation including some of the following:

The Patient had a significant history of alcohol dependency and was under the influence of alcohol when he attended the A&E department. The Patient expressed his wish for help in stopping drinking. The Patient had a history of self-harm / suicide attempts along with previous Psychiatric inpatient unit admissions.

During his assessment with the MHLS Practitioner on 11th March 2018, the Patient presented with lowness in mood with suicidal thoughts and requested admission to a Psychiatric inpatient unit. The Patient stated that he would jump out of a window or cut his wrists if he were to be discharged home.

The Patient lived alone and isolated himself away from existing family members.

In terms of Care and service delivery problems the following were identified:

Patient was requesting admission, expressing thoughts of harming self-harm/suicide ideas. Admission was considered and a number of attempts were made to secure both an NHS and private beds. All attempts were unsuccessful and the Patient declined to remain within the department until a bed was secured. Whilst a number of attempts were made to secure an older adult inpatient bed, there is no documented evidence that consideration was given to locate a younger adult inpatient bed for the Patient and the MHLS Practitioner was unable to recall if this was considered. It has since been ascertained that on the evening in question, there were two vacant male beds on Brook ward Penn hospital. The MHLS team manager has confirmed that considering a younger adult inpatient bed for an older adult Patient is an option for consideration and that, on this occasion, admitting the Patient to a younger adult inpatient bed had not been explored.

There is no recorded evidence that the risk assessment was updated to reflect the change to the Patient's treatment plan and current and up to date

	next of kin details were not available to the Older Adult CHTT team.
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 there was inadequate communication and history taken as part of the assessment process by the MHLS nurse. Specifically there were failures to record the fact he had attempted to strangle/suffocate himself whilst in the A and E department and gain entry to the drugs trolley. 2. Further efforts should have been made to find a suitable bed given his high level of risk and previous history.
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. You may wish to consider further reviewing the guidance on managing patients with significant risk and ensuring full and accurate history is taken as part of the assessment process. 2. You may also wish to consider reviewing the communication between the MHLS team and Hospital staff to ensure adequate records and details are passed between the staff to have as complete a picture as possible.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 22 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; Family. 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	**18 April 2018** Z Siddique **Mr Zafar Siddique** **Senior Coroner** **Black Country Area**