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:** **Chief Executive, Professor Heather Tierney – Moore OBE** **Lancashire Care NHS Foundation Trust**
1	**CORONER** I am Alan Wilson, Senior Coroner, for the area of Blackpool & Fylde
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** **The medical cause of death was recorded as follows:** **1 a Multiple injuries due to impact of fall** **The conclusion was one of SUICIDE.** In paragraph 3 of the Record of Inquest where when and in what circumstances Adam came by his death the jury stated as follows: Adam James Carter died on 10 September 2017. The time of Adam's death was recorded at 19.03 hours, at Blackpool Victoria Hospital. Adam suffered multiple injuries as a result of falling from the 5th floor of Talbot Road car park in Blackpool. Prior to this event, Adam had absconded from the Harbour Mental Health facility during escorted leave. Adam was under treatment at the harbour for bi polar affective disorder. He was suffering from mania on admission and appeared to be responding to treatment. As the mania was largely under control from mid August onwards. Prior to absconding, Adam appeared settled and there was no evidence to suggest that Adam would abscond. He had previously been on 9 periods of escorted leave without incident, and he had not expressed any self harm or suicidal ideation in that period. It is likely that Adam asked a member of the public to call an ambulance on Church Street and identified himself as a patient at the Harbour at 17.45 hours, prior to making his way to the 5th floor of the car park where the event took place. We conclude that alcohol and substance abuse played no causal role in his death or the events leading to it.
4	**CIRCUMSTANCES OF THE DEATH** Adam Carter was confirmed a 1903 hours on 10 September 2017 at Blackpool Victoria Hospital having been transferred there after having reportedly fallen from the 5th floor of a multi-story car park in Blackpool town centre at around 1755 hours earlier that afternoon.

	Some two hours previously Adam had absconded from The Harbour mental health facility in Blackpool as he commenced a period of escorted leave with a member of staff – that leave had been granted on the basis that he could leave the building with the staff member but not go beyond the hospital grounds perimeter. In fact CCTV footage showed him running off through the doors of the building and initially being pursued by the staff member who quickly altered other staff and police were contacted. Between Adam making off from The Harbour and the reported fall from a car park there were no sightings of Adam. The only evidence available was that a member of the public rang the ambulance service at re that a call had been made to the ambulance service from Church Street in Blackpool at 17.45 hours that day informing a man had approached him and asked he call for an ambulance but that upon him doing so the person had walked off but after informing him that he had absconded from The Harbour and was a "mental patient". There is no further reported sighting of Adam until shortly before 6pm when eyewitness reported seeing Adam's body falling to the pavement and one witness had been on the top floor of the car park when he saw Adam at the top of the car park climb over a fence and drop himself over the edge. A subsequent post mortem examination confirmed Adam had died from multiple injuries as a result of impact trauma. Adam had a history of involvement with mental health services from approximately 2000. His parents with whom he lived had noticed deterioration in his condition from 12th July 2017. That deterioration continued and he was detained under section 2 Mental Health Act 1983 for a period of assessment [and later detained under section 3 of that Act]. Initially detained in a mental health ward in Blackburn he was transferred to The Harbour before the end of July 2017. His therapeutic team felt his condition improved and by mid-August 2017 he began to utilise escorted ground leave and plans were being put in place form him to be discharged to a supported living placement close to his parents' home. Adam was known to have expressed suicidal thoughts previously but it was not felt that he had tried to actively harm himself previously. By 30th August 2017 the therapeutic team felt he was settled, there was no evidence of psychosis, and he had used his periods of leave without difficulty, and on 4TH September 2017 he was "stepped down" from a Psychiatric Intensive Care Unit [PICU] to an acute hospital ward. An independent Consultant Psychiatrist provided an independent opinion upon the care afforded to Adam and amongst his conclusions he reported that Adam had suffered a relapse into severe mania in July 2017, that his care and treatment was of an acceptable standard, that his mania had been largely controlled by mid-August 2017; that the team had taken sensible and appropriate measures to manage the risk of self – injury, that it was reasonable to assume the risk of completed suicide and of Adam absconding was low and that in his view Adam's death could not have been predicted by his Multi-Disciplinary 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 **MATTER OF CONCERN** is as follows:

The concern relates to record keeping.

During his independent review of this matter, a Consultant Psychiatrist identified some discrepancies within the medical records including the following:

- Although he felt that the therapeutic team had an understanding of the extent to which Adam posed a risk of:

- aggression and violence;
- self harm;
- suicidal behaviour;
- absconding;

He did not feel that these risks were documented or clearly formulated in the medical notes.

- He stated that there was very little detail in the documentation as regards Adam's use of his leave nor of care planning of his leave. The rationale for leave having been granted was not recorded nor were the benefits and risks associated with leave.

- He was unable to find a record of an assessment of Adam's clinical state by nursing staff immediately before the period of escorted ground leave on 10th September 2017 as required by trust policy [although he did not feel that this would have any bearing on the decision to afford Adam leave on this occasion].

- He could not find a copy of the Leave Authorisation that granted Adam leave and felt that documentation of leave fell short of the guidance laid out in the Trust policy for the authorisation of section 17 leave of absence.

Clearly the quality of record keeping is important in the context of a detained mental health patient. Adam had spent some time in a Psychiatric Intensive Care Unit and then a number of days on an acute inpatient ward prior to the events of 10th September 2017.

The level of risk such a patient poses as regards issues such as the risk of self harm and absconding are fundamental to the care provided. Plans were being made for Adam to be discharged and into the community rather than back to his parents' home and he was being afforded the opportunity to build towards that discharge by granting him leave which was an important step in progressing towards that goal. However, such decisions need to be made appropriately and informed by how the risk a patient poses is viewed at that time. It is vital that the basis for such decisions is clear from the records.

If this does not happen then I have a concern that future deaths may result – inevitably patients such as Adam are cared for by a team consisting of different staff performing different shifts. Staff taking over the care of a patient such as Adam ought not to have to rely on the verbal information provided to them at a handover of that patient's care but need to have the opportunity to read the records and to remind themselves how the risk their patient poses is viewed by for example the relevant Consultant Psychiatrist, and why he or she has been granted leave.

The court heard that escorted grounds leave was granted to Adam but that nursing staff had discretion as regards whether that leave went ahead and they may exercise such discretion subject to how Adam presented, his behaviour on the ward etc. If they cannot access accurate and informative records, such staff may make decisions that are not in the interests of their patients. Leave may proceed on a basis not felt to be safe. Leave may be declined because the staff member – unable to access the relevant information – decides to err on the side of caution and declines leave to the detriment of that patient's progress and the condition of his / her mental health.

	It seems to me that if an independent consultant psychiatrist has conducted a review and identified these issues in relation to records it should inevitably prompt a concern on my part that unless I write a report such as this one future deaths may result. I therefore raise the concern. I cannot be prescriptive about what action should be taken and I make no recommendations but simply raise the issue. At the conclusion of the inquest, I indicated to the Properly Interested Persons that I proposed to write to the Department of Health by way of a report in accordance with the provisions of paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009.
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 10th September 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 of Adam Carter • Chief Executive, Blackpool Council • Care Quality 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	A.A.Wilson **Alan Wilson** **Senior Coroner for Blackpool & The Fylde** **Dated: 12th July 2018**