IN THE WEST YORKSHIRE (WESTERN) CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Denton Donovan DUHANEY
A Regulation Report – Action to Prevent Future Deaths

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1. The Chief Executive of the Mid Yorkshire Hospitals NHS Trust
2. The Chief Executive South West Yorkshire Partnership NHS Foundation Trust

1 CORONER

I am Mary Burke Assistant Coroner for the area of West Yorkshire Western Division.

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

Inquest opened 12th July 2019 into the death of Denton Donovan Duhaney
Inquest concluded 30th March 2021

I recorded the medical cause of Mr Duhaney's death was due to Hanging (Asphyxia) and a conclusion of suicide

4 CIRCUMSTANCES OF THE DEATH

On the 22nd June 2019, Mr Duhaney had been admitted to the Accident and Emergency Department of Dewsbury District Hospital with both physical and mental health concerns.

He was assessed by a nurse from the Psychiatric team, who recommended he should be admitted as an informal patient on to a psychiatric ward. However, no bed was available and he was therefore transferred to Pinderfield's Hospital early on the morning of the 23rd June 2019 and admitted on to the Acute Medical Assessment Unit.

Mr Duhaney underwent a further mental health assessment at 17.00hrs by a member of the Wakefield Home Based Treatment team following a request by the Kirklees Home Based Treatment team within whose area Mr Duhaney resided.

At this point a psychiatric hospital bed could still not be found within the area (Mr Duhaney had requested to remain in the area as his partner was gravely ill).

At the time of this assessment an alternative treatment plan was agreed with Mr Duhaney namely that when he was physically well enough to be discharged, he would be provided

with care and support in the community setting by the Kirklees Home Based Treatment Team. At the time of this assessment Mr Duhaney was assessed as being at high risk of further mental health deterioration.

Following assessment the Wakefield Home based Treatment team referred Mr Duhaney back to the team in Kirklees.

It appears that at no time either at the time of transfer or during his admission was Mr Duhaney referred to the psychiatric services within Pinderfield's Hospital.

In the ensuing days the Kirklees Home Based Treatment team made telephone contact with both Mr Duhaney and Acute Medical Assessment unit, leaving contact telephone details and a request that they be contacted and notified when Mr Duhaney was to be discharged.

It appears Doctors on the ward believed Mr Duhaney was awaiting a hospital Psychiatric assessment.

On the afternoon of 25th June 2019 Mr Duhaney approached a member of the nursing team at the nurses station and stated he wished to self-discharge.
Blood test results were still awaited. The nurse gave evidence at the inquest, she stated that she spoke to a female doctor the identity of whom she could not recall advising her of Mr Duhaney's wishes, the doctor did not undertake an assessment upon Mr Duhaney, the nurse proceeded to warn Mr Duhaney that his discharge was against Medical advice and got him to sign the appropriate form.

The nurse in evidence stated she was unfamiliar with the trusts protocol document "Standard Operating Procedure for Managing the Discharge of Patients.
Mr Duhaney left the hospital.
No hospital staff member contacted Kirklees Home Based Treatment Team of Mr Duhaney's self discharge.

The lead Investigator of a Serious Incident Investigation Report undertaken by South West Yorkshire Partnership Trust in respect of the involvement of Home Based Treatment Teams stated in evidence that he was advised by the Modern Matron at Pinderfield's Hospital that it was normal Practice of the hospital not to arrange follow up in the community in these circumstances when it was planned for if, the patient self discharges.

Five days later on 30th June 2019 a staff member from Kirklees Home Based Treatment team contacted Pinderfield's Psychiatric Liaison Team seeking an update upon Mr Duhaney, only to be advised that Mr Duhaney had self discharged 5 days previously. Immediate steps were taken by Kirklees Home Based Treatment to try and make contact with Mr Duhaney to no gain. As a result the police were contacted who attended at his home, now the early hours of 1st July 2019, they forced entry and found Mr Duhaney with a length of medical plastic piping around his neck which had been secured to an adjoining door handle, his death was confirmed a short time later by an attendant paramedic.

Mr Duhaney appeared to have been dead for some time, he was still wearing hospital clothing beneath his own clothing.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:
1. Mr Duhaney was a patient at Pinderfield's Hospital between 23rd and 25th June but at no time was he assessed or receive treatment by the in house psychiatric team despite the fact that he had an underlying psychiatric presentation.

2. Pinderfields hospitals discharge protocol does not appear to have been adhered to when Mr Duhaney expressed a wish to self-discharge.

3. No one from Pinderfield's Hospital contacted Kirklees Intensive Home Based Treatment Team to notify them of Mr Duhaney's self discharge.

4. Kirklees Home Based Treatment Team last had contact with Pinderfield's Hospital on 24th June 2019. It was 6 days later that they made a further call to the hospital seeking an update upon Mr Duhaney.

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 3 August 2021. 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]

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.

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P Halifax for. M.T. Burke

Dated: 9th June 2021