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:** **1. Rt. Hon Thérèse Coffey MP, Secretary of State for Health.** **2. The Chief Executive of Central and North West London NHS Foundation Trust.** **3. His Honour Judge Thomas Teague QC, The Chief Coroner for England and Wales.**
1	**CORONER** I am Christopher Williams an Assistant Coroner, for the Coroner Area of Inner London South (Southwark Coroners Court).
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 3 April 2019 an investigation commenced into the death of **Daniel John O'Sullivan,** born 11 December 1979, who died on the 27 March 2019. The investigation concluded at the end of the inquest on 12 October 2022. The medical cause of death was: 1(a) Asphyxia 1(b) Hanging II Use of cocaine. The Conclusion of the Inquest is contained in the following extract from my narrative conclusion: *"… Based on Daniel's psychiatric medical records and evidence from an independent expert psychiatrist there were failures in the management of Daniel's risk of self-inflicted death and in the treatment of his delusional disorder.* *The decision to rescind his s.2 MHA detention on 25/3/19 was inadequate due to failures to update a risk assessment for self-inflicted death by taking account of his most recent threat of suicide on 13/3/19 and his recent articulation, during admission to Amazon ward,* [redacted] *The decision to rescind s.2 was further undermined by a failure to formulate a treatment Care Plan which should have sought to treat his psychosis using antipsychotic medication and treatment of his drug misuse through psychological therapy. The decision to rescind was also undermined by a failure to recognise that Daniel lacked capacity through his inability to appreciate that his delusional beliefs were not grounded in reality.*

	Rescinding Daniel's detention under s.2 MHA was a missed opportunity to assertively treat his psychosis and drug use in hospital. The combined effect of his psychotic condition with illicit drugs had driven Daniel's recent attempts to end his life. This missed opportunity made a significant contribution to his death two days later. *Based on expert psychiatric evidence it was likely that Daniel had lost touch with reality at the time of his death, due to his delusional condition [redacted] as such he was not capable of understanding the consequences of his deliberate actions."*
4	**CIRCUMSTANCES OF THE DEATH** At about 05:46 am, on 27/3/19, Daniel was discovered, deceased, [redacted] At the time he was a voluntary psychiatric patient at St Charles Hospital, Central North West London NHS Trust (CNWL) and was harbouring delusional beliefs that he was being pursued by criminals who were intent on killing him. [redacted] He had been transferred to St. Charles on 19/3/19 whilst detained under s.2 Mental Health Act 1983 (MHA) following recent self-harming incidents. [redacted] He was returned to the Gordon hospital where he was a voluntary patient. He subsequently absconded from the Gordon Hospital and was discharged in absentia. [redacted]. The police took him to Kings College Hospital where he was detained under s.2 MHA. Whilst detained under s.2 he was transferred to St Charles Hospital on 19/3/19 where he disclosed, during admission, a plan to hang himself the following week when he received his benefits. On the 25/3/19 he became a voluntary patient when s.2 detention was rescinded following assessment by a consultant psychiatrist. On the 26/3/19 he was permitted to leave the hospital unescorted at about 16:20 pm. He failed to return to the ward by 21:00 pm and staff called the police after midnight on 27/3/19.
5	**<u>CORONER'S CONCERNS</u>** From the evidence I received, at the inquest, there are matters giving rise to concern. In my opinion there is a risk that future deaths could 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)** On completion of the inquest, I found the decision to rescind detention under s.2 on 25/3/19 was undermined in two essential respects: a) A failure to update a suicide self-harm risk assessment. b) A failure to formulate a Care and Treatment plan identifying core treatment needs.

A Serious Incident Investigation (SII), commissioned by CNWL, completed on 9/9/2019, investigated the Risk Assessment element and made recommendations which I heard from a CNWL witness had subsequently been implemented and I am satisfied that this risk to life has been satisfactorily reduced.

However, I remain concerned that the Care and Treatment plan aspect was not identified by the SII and as such no recommendations were identified and followed up.

The psychiatrist who rescinded s.2, on 25/3/2019, was unable to participate in the inquest through illness.

As a result, I instructed an independent expert psychiatrist who gave evidence that there had been no treatment plan addressing Daniel's core treatment needs.

The core treatment needs were that Daniel required antipsychotic medication to control his delusional beliefs and psychological intervention to address his substance misuse which exacerbated his delusional beliefs.

The expert also identified from statements and medical records that Daniel lacked insight into his mental health conditions and thereby lacked capacity. The treatment Daniel required was twofold. Assertive treatment of the delusional disorder with antipsychotics, whilst detained under s.2, to achieve stability, coupled with psychological therapy to address the illicit drug use.
I heard evidence that antipsychotics could not commence until the results of liver function tests were available, but this did not persuade the expert, that recission of s.2 was correct.

The psychiatrist who rescinded s.2 on 25/3/19 was interviewed by the SII but the care and treatment plan aspect was not explored by that investigation.

My concern is that failures in the formulation of a Care and Treatment Plan made a significant contribution to the death and this failing was not exposed until the inquest when it could have been identified much earlier by the SII in September 2019.

The fact that a Care and Treatment plan was not formulated gives me concern that the mistake could be repeated in future and my concern is compounded by the SII failing to investigate and make recommendations arising from this issue.

Accordingly, I am reporting this matter to the Minister for Health and CNWL Trust to make such recommendations as they see fit arising from the expert evidence uncovered by the inquest so that any necessary lessons can be learned.

2) My second concern is the poor contemporaneous documentation of the grant of unescorted leave from the hospital and the time taken to alert the police when Daniel failed to return on 26/3/19 by 21:00 pm. A ward nurse eventually contacted the police after midnight.

i) I am concerned that an earlier call to the police may have prevented the death, because Daniel was recorded on General Security Zone (GSZ) cameras at 22:21 leaving Vauxhall bridge, and returning, on foot at 23:48. An earlier call might have enabled police to intervene before he was able to commence the actions which ended his life.

ii) The ward manager claimed in evidence that he had instructed others to call the police when Daniel failed to return at 21:00. However, this was not documented anywhere in the medical records and a leave book with handwritten entries went missing after the death. The missing leave book was not investigated by the SII.

	iii) A nurse who called the police, sometime before 00:30 according to the medical records, or at 01:10 according to police records, was not interviewed by the SII. I found these investigative deficits troubling because the learning of lessons in patient care depends, in part, on an early SII by the hospital concerned so that risks to patient safety can be identified to enable recommendations and improvements long before an inquest conclusion. The delay in reporting the failure to return to the Ward was a factor that contributed to the dangerous situation already created by rescinding s.2. I am nonetheless concerned that, in general, psychiatric patients being tested on voluntary leave are a vulnerable group and as such failures to return should be reported with expedition not only because they may be a danger to themselves, but also due to a risk of being preyed upon by others. I therefore wish to report this matter to the Minister for Health and CNWL Trust to make such recommendations as they see fit including the adequacy of the SII investigation.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 the **16 December 2022.** I, the coroner, may extend the period. Your responses 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 who may find it useful or of interest: 1. JMW Solicitors LLP representing the family of Daniel O'Sullivan 2. Weightmans LLP solicitors for CNWL NHS Trust 3. Metropolitan Police Service 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	**Dated:** **Signed:** **21st October 2022** **Christopher Williams**