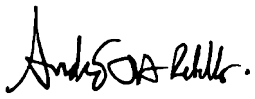
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 NHS England & NHS Improvement (PFDs)** **2 Secretary of State for the Department of Health and Social Care, Mr S Barclay**
1	**CORONER** I am Andre REBELLO, Senior Coroner for the coroner area of Liverpool and Wirral
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 04 October 2019 I commenced an investigation into the death of Stephen Norman RICHARDSON aged 47. The investigation concluded at the end of the inquest on 22 June 2023. The conclusion of the inquest was that: ***Stephen Norman Richardson died from the effects of a self-inflicted ligature [redacted], however his intention in doing so remains unclear as the evidence presented Stephen had a fear of dying by suicide.***
4	**i. CIRCUMSTANCES OF THE DEATH** ii. The Jury found, iii. Self-inflicted ligature on 24th September 2019 at Sid Watkins Unit. Stephen Norman Richardson is a male who was 47 years of age at his time of death. Stephen had suffered with treatment resistant paranoid schizophrenia, from the age of 18. iv. Following a number of medications being unsuccessful in managing Stephen's condition and also a long period of inpatient treatment, Stephen was prescribed clozapine in 2006. Clozapine allowed Stephen to live independently and be able to mostly manage his mental well-being. v. Stephen was regularly monitored by blood testing and in 2018, he had a number of results which concluded that clozapine could no longer be used to treat Stephen's condition. vi. The Jury have reached the conclusion that it was reasonable to stop the clozapine at this time. However, the Jury are of the view that there were missed opportunities to treat the neutropenia with a view to restart clozapine and also no exploration of whether other medication that Stephen was prescribed could have been the cause of his neutropenia, rather than clozapine. vii. Almost immediately following clozapine being stopped Stephen's mental health deteriorated. On the 20th May 2018 there was a marked deterioration in Stephen's mental health. A schedule of daily visits was put in place in recognition of this. viii. On 24th May 2018 there was a further deterioration in Stephen's mental health. The view at this time was that Stephen met the criteria to be sectioned under the Mental Health Act. However, he was not sectioned at this time and the Jury heard that this was due to no bed being available on an acute mental health unit. ix. Stephen was advised that the plan for him was to be admitted to hospital 2 days later. A plan was put in place for the community crisis team to visit Stephen at his home at least twice a day. x. On the 26th May 2019 Stephen was still not admitted or sectioned under the Mental Health Act. xi. Visits from the Mental Health Team had not been completed as previously discussed. xii. On May 29th Stephen was visited and the conclusion from this visit was that Stephen should be

		prioritised for admission.
	xiii.	Later on that day Stephen attempted to hang himself.
	xiv.	The Jury are of the conclusion that the failure to secure a bed on an acute Mental Health Unit for Stephen was a gross failure that contributed to the attempted hanging. Furthermore, this failure also contributed to Stephen sustaining a hypoxic brain injury, and the damage he sustained to his throat, which resulted in Stephen needing to be peg fed.
	xv.	Whilst as an inpatient at the Royal Liverpool Hospital, Stephen's behaviour became cause for concern, this resulted in the plan for Stephen being that he would be admitted to Clock View rather than the Brain Injury Unit, A bed was found on 28th June 2019. Stephen became an inpatient at Clock View 2nd July 2019.
	xvi.	Stephen was viewed as having a settled period at Clock View.
	xvii.	On 11th July 2019 Stephen was transferred to the Brain Injury Unit, this was described as an emergency transfer due to the need for his bed to be used by another patient.
	xviii.	The Jury are in agreement with Stephen's family in that this transfer was not in Stephen's best interest, as there had been no plan of care established for Stephen at the time of transfer. Whilst being an inpatient at the Brain Injury Unit, there were incidents of Stephen assaulting staff. Due to these incidents Stephen was returned to Clock View on 24th July 2019.
	xix.	On 14th August 2019 [redacted] was found outside Stephen's room, when asked about the [redacted], Stephen said that it fell out of his pants.
	xx.	Following this incident a written record was made and the information was verbally shared at the start of the handover. However there was no alteration to Stephen's risk assessment.
	xxi.	In addition to this there was no safeguarding plan implemented to reflect the incident and any possible related risks.
	xxii.	The jury have noted that, prior to the cord being found Stephen had requested to call his mother. Following Stephen being unable to contact his mother the cord was found.
	xxiii.	The jury have concluded that non-completion of the risk assessment document was in itself a significant failure. On discussion of a transfer back to the Brain Injury Unit family shared concerns as to the ligature risks, and the loss of protective factors such as familiarity with his surroundings and staff.
	xxiv.	At the unit family were also in disagreement with a transfer to the Brain Injury Unit at this stage due to their views that the physical environment at the unit being a risk to Stephen.
	xxv.	Following an assessment of Stephen a phased transfer plan was proposed.
	xxvi.	The Jury have concluded that this was a significant failure in that this plan was not communicated to relevant persons.
	xxvii.	In addition to this the Jury conclude that in the one instance that the plan was shared it was misunderstood by bed management. This is viewed by the jury as a missed opportunity for Stephen.
	xxviii.	Despite the proposed phased return to the Brain Injury Unit and the concerns raised by the family Stephen was transferred with immediate effect on the 16th September 2019. Between 7th September 2019 and the 25th September 2019, no risk assessment was completed either by Clock View or the Brain Injury Unit.
	xxix.	The Jury concluded that this was a serious missed opportunity as there was an absence of documentation to inform care planning and safeguarding steps for Stephen.
	xxx.	Documentation that was completed for Stephen prior to 24th September 2019 recorded occasions of Stephen having suicidal thoughts.
	xxxi.	It is also documented that Stephen had a recognition of his thoughts at this time and requested support in an effect to keep himself safe.
	xxxii.	On the day of the ligature incident (24th September) observations from ward staff state that he was settled, watched TV, spent time in his room, showered, went shopping and wash and dried his clothes. Stephen's sister also visited him that evening.
	xxxiii.	Following the staff handover on the ward, Stephen's observations show that there was a change in Stephen's presentation. He is noted as refusing his medication, refusing access to his room and throwing an item around his room. Stephen is also recorded in observations as being anxious. The Jury heard in evidence that there was no qualified mental health nurse on shift working that evening.
	xxxiv.	Stephen's behaviour continued and a decision was made to allow him to have time to calm down. At 23:20 Stephen spoke to staff to request that he could make a telephone call to his mother. Stephen was bare chested and he was asked to put a top on but refused to do this.
	xxxv.	At 23:40 Stephen repeated his request to call his mother again. He was told that he could use the phone in the office, but refused and said that he had changed his mind, saying it did not matter.

	xxxvi.	A short time later staff noticed that Stephen's room was in darkness. A light on a mobile phone was shone into the room, This was in an attempt to see where Stephen was in the room. The door of Stephen's room was found to be barricaded and the jury heard in evidence that it took 4 - 6 minutes to clear the barricade and enter the room.
	xxxvii.	Evidence was also given that no noise was heard at any time of Stephen barricading his bedroom door. On entering the bedroom, Stephen was found ligatured behind the bathroom door.
	xxviii.	It has been discussed in court that the procedure to be followed at the Brain Injury Unit in such circumstances is to call 2222 and 999 to alert emergency services. Although staff called 999 at 23:53 no call was made to 2222. The Jury have concluded that there were missed opportunities due to there being no knowledge of the correct procedures to follow.
	xxxix.	However it is acknowledged that this failure would not have altered the outcome for Stephen. The Jury also conclude that lack of communication between persons on duty was a failure to respond appropriately to Stephen's behaviours.
	xl.	For example, there was no information shared as to the [redacted] being found 4 weeks earlier. The sharing of the incident could have allowed for additional risk planning.
	xli.	As a jury we would like to offer Stephen's family our sincere condolences.
	xlii.	Stephen was transferred to ICU at University Hospital Aintree on the 24th September 2019 and sadly passed on 28th September 2019. As a result of his extensive brain damage the decision was made by his family to withdraw his life support. Stephen was pronounced dead."
5	**CORONER'S CONCERNS**	
	During the course of the investigation my inquiries revealed 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: (brief summary of matters of concern) It was clear from the investigation that at the time of Stephen ligaturing in May 2019 there was an national shortage of acute pyschiatric beds to treat patients in the community suffering with mental disorder of a nature or degree which necessitated immediate assessment treatment and care as an inpatient. The evidence heard has confirmed that that parlous situation has not improved.	
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 August 17, 2023. 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] **North West Ambulance Service NWAS** **Merseycare NHS Trust** I have also sent it to	

	Living with Shizophrenia **MIND** **Richmond Fellowship** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 22/06/2023**  **Andre REBELLO** **Senior Coroner for** **Liverpool and Wirral**