## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>[redacted]<br>Clinical Director- CARMHS,<br>West London NHS Trust,<br>Trust Headquarters,<br>1, Armstrong Way,<br>Southall,<br>Middlesex.<br>UB2 4SD. |
| 1 | **CORONER**<br><br>I am Professor Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West London |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 4th July 2023 evidence was heard touching the death of Mr Oleg Khala. He had been found deceased on the 1st January 2022, aged 56 years.<br><br>**Medical Cause of Death**<br><br>1 (a) Hanging<br><br>**How, when, where the deceased came by his death:**<br><br>Mr Khala suffered with severe and enduring mental and neurodevelopmental illnesses which together made his needs complex and him vulnerable.<br>He had a past history of non-engagement with services in part due to autistic spectrum disorder.<br>From autumn of 2021 his mood began to fall.<br>On the 17th December 2021 and 28th December 2021 he attended Chelsea and Westminster Hospital requesting admission due to suicidality and sleeplessness.<br>On both occasions informal admission was recommended by the psychiatric liaison services, but he was discharged for community care by the Crisis Assessment and Treatment Team (CATT), without consultant advice.<br>Given his known vulnerability, lack of engagement, complexity and risk he should have been admitted, particularly after community treatment had failed due to his non-engagement between 18th December 2021 and 28th December 2021.<br>On 1st January 2022 at approximately 0940, he was found deceased hanging [redacted] by Parks Police. |

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| | There were no suspicious circumstances.<br>If he had been admitted on 28th December 2021, he would probably would not have died at this time,<br><br>**Conclusion of the Coroner as to the death:**<br><br>Suicide |
| 4 | Extensive evidence was taken during this inquest from many live witnesses and multiple statements and reports were read and exhibited. Of relevance to this report:<br><br>Mr Khala lived alone, socially isolated in temporary accommodation. The difficulties that he experienced with interpersonal relationships with neighbours and officials rendered him very vulnerable. His main support and advocate was a social worker of Glasshouse homeless charity. He had moved multiple times and had had come under the care of different Mental Health Services. He had diagnoses of autistic spectrum disorder, ADHD, schizoaffective disorder and an historic diagnosis of bipolar disorder. He was on long term medication of sodium valproate as a mood stabiliser and risperidone as an antipsychotic.<br><br>He came under the care of West London Mental Health Services in February of 2021, referred from Croydon. He was allocated to the Mental Health Integrated Network Team (MINT). He did not have a care-coordinator despite his severe and enduring mental health issues, and ongoing symptomatology. He was placed on a list for a care-coordinator in July 2021, but had not been allocated one prior to his death, due to a shortage of and waiting list for care-coordinator provision.<br><br>In the past he had been admitted on several occasions, some under section, and had a history of overdose, and throwing himself in front of a bus and talked of possibly jumping off a building in around July 2021. His psychiatrist noted that his conditions would put him at risk of impulsive behaviour, including self-harm.<br><br>In around October of 2021, his prescriptions for his mood stabiliser and antipsychotic were stopped, due his non engagement with his GP, for about three weeks.<br>These were restarted, but he experienced side effects as they were recommenced.<br>At the time of his death toxicology revealed that he had stopped taking his medication. This was not appreciated by the clinicians caring for him.<br><br>The Glasshouse social worker, from around October noticed a real change n his mood and behaviour- mood falling and becoming anergic and attempted to support him and accompany him to appointments and assist with social issues.<br><br>On the 6th December 2021 he was seen for assessment by his psychiatrist through MINT. He presented as capacitous, with some insight, complex, and intelligent. He was able to give a good account of his past experiences and issues. His diagnoses were considered, and further assessment was required. Follow up appointments were offered but sadly he had died before these occurred.<br><br>On the 17th December 2021 he attended Earl's Court Station with a plan to jump in front of a train, but asked for help of staff. He was taken by police to Chelsea and Westminster Hospital where he was assessed by liaison psychiatry and requested admission. He gave a history of intrusive suicidal thoughts, sleeplessness due to issues with a neighbour and to be at risk of suicide. Sleeplessness was a relapse indicator for him, and his social isolation was recognised. Admission was recommended by psychiatric liaison. |

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| | He was referred to the CATT who found him not to be suicidal and discharged him with a tablet of diazepam and for follow up with MINT without discussion with a consultant nor psychiatric liaison.<br><br>Whilst the records taken by psychiatric liaison were full and descriptive and gave a thorough impression of appearance and behaviour, presentation and assessment of his presenting complaints, the assessment by CATT was generic in style. Evidence taken live from CATT was that Mr Khala was underplaying his suicidality to CATT, but nevertheless he was discharged.<br><br>The court heard that more than half of patients assessed by CATT for informal admission are discharged for community follow up, and that one of the roles of CATT is specifically to explore alternatives to admission. Patients discharged without admission by CATT are not discussed with the on-call psychiatrists, whilst patients to be admitted are.<br><br>There is an on-call consultant psychiatrist at all times for patients to be discussed.<br><br>Attempts were made to follow up Mr Khala by MINT but these were unsuccessful.<br><br>On 28th December 2021, Mr Khala re-presented at Chelsea and Westminster with suicidality and reassessed by a different psychiatric liaison nurse. Again, a thorough assessment was undertaken. He was found to be suicidal, avoiding eye contact , intermittently covering his face with his face mask when distressed, to have slept only one night since he was last seen, and to have been wandering the streets at night rather than go home, and he requested and required admission to keep him safe due to his suicidality, to review his medication and care needs.<br><br>He was again seen by CATT. The notes recorded were again generic, and tick box in style. In live evidence it was accepted that he did have on going suicidal thoughts but no plans nor intent. His complexity appeared underappreciated and many questions put to the CATT witness based upon the assessment by psychiatric liaison centring on his demeanour and sleeplessness, which had taken place just a few hours previously, were not answered clearly by the CATT witness. The witness claimed that admission had been discussed with Mr Khala but declined and follow up by MINT agreed with him, despite its previous failure. The discussion which the CATT witness stated to have taken place about admission was not recorded in the notes.<br><br>The court had some questions of credibility of evidence of the CATT witness who saw Mr Khala on 28th December 2021.<br><br>Mr Khala was discharged with two tablets of zopiclone for MINT follow up. This occurred despite two admissions being requested in a short time, the differing views of psychiatric liaison on both the attendances, the recent failure of the same plan, his risks including social isolation, age, sex, impulsivity, complexity and on-going suicidal ideation, his demeanour and the recurrence of his relapse indicator of sleeplessness. His case was also not discussed with the on-call psychiatrist.<br><br>The psychiatrist from MINT stated that such cases should and could have been discussed with the on-call psychiatrist, especially given the differing views of psychiatric liaison and CATT, and his complexity, risk and vulnerability.<br><br>The view of the psychiatrist was that Mr Khala should have been admitted and would have benefited from admission with the opportunities that admission would have afforded to Mr Khala to keep him safe and review his treatment and care plan. |

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| | This was especially so on the 28th December 2021 after the previous plan had failed and yet was tried again.<br><br>The evidence was that all cases whether discharged or admitted should be discussed with the on-call psychiatrist, that there was remains, a shortage of care-coordinators and Mr Khala should have had one, and that MINT has no access to specialist advice or assessment for ASD or ADHD within MINT which if this was available would also have been of potential benefit to patients such as Mr Khala. |
| 5 | **Matters of Concern**<br><br>1. The generic, tick-box style of history recording by CATT which does not paint a full and proper picture of the mental health of the patient, especially compared to the assessments of psychiatric liaison, are such that risk may be unrecorded and under appreciated by CATT and patients thus be put at risk.<br><br>2. That the role of CATT to look for alternatives to admission may risk CATT discharging patients who would benefit from admission and risk the repeat of making treatment plans that had recently failed such as in this case. Rather than looking for admission alternatives being a core function, should CATT rather better be focussed on the best treatment plan for the individual patient and thus admission being viewed as a clear option where appropriate rather a last resort, as it often appears to be presented in such cases before the coroner?<br><br>3. That the provision of care-coordinators be increased and improved so that patients who require them have ready access at the time of need and are not placed on a waiting list.<br><br>4. That patients to be discharged by CATT, as well as patients to be admitted are discussed with the on-call psychiatrist so that plans may be reviewed, and thus the risk of not admitting patients who would benefit from and/ or require admission such as Mr Khala, are less likely to be discharged inappropriately.<br><br>5. That where psychiatric teams differ in their assessments such as CATT and psychiatric liaison, as occurred here, patients are not discharged until opinion is sort from the on-call consultant and re-discussion taken place between those with differing views.<br><br>6. That expertise covering neurodevelopmental disorders such as ASD and ADHD is available as part of MINT. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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. It is for each addressee to respond to matters relevant to them. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report. I, the coroner, may extend the period.<br><br>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. |

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| 8 | **COPIES and PUBLICATION**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons :<br><br>[redacted], sister of Mr Khala, and his two children.<br><br>[redacted]<br>Consultant Psychiatrist,<br>MINT,<br>Claybrook Road,<br>London.<br>W6 8NF<br><br>[redacted]<br>Team Manager,<br>Hammersmith and Fulham Crisis Assessment Team<br>Claybrook Road,<br>London.<br>W6 8NF.<br><br>[redacted]<br>Glass Door Homeless Charity,<br>Argon,<br>Argon Mews,<br>London.<br>SW6 1BJ.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **6th July 2023.**<br><br>  <br><br>**Professor Fiona J Wilcox**<br><br>**HM Senior Coroner Inner West London**<br><br>**Westminster Coroner's Court**<br>**65, Horseferry Road**<br>**London**<br>**SW1P 2ED**<br><br>**Inner West London Coroner's Court,**<br>**33, Tachbrook Street,**<br>**London.**<br>**SW1V 2JR**<br>**Telephone:0207 641 8789.** |

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