REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of Nottinghamshire
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 16th July 2022, I commenced an investigation into the death of Gerard Murray. The investigation concluded at the end of the inquest on the 4th August 2023 The conclusion of the inquest was suicide
4	**CIRCUMSTANCES OF THE DEATH** Gerard died on the 16th July 2022. He was found deceased, [redacted] at 15.20 hours on that day. This location was an approximate half mile walk from Bassetlaw Hospital, where Gerard had been an inpatient on the mental health ward B2. [redacted] He had been admitted to ward B2 on 29.6.22, with low mood and suicidal thoughts and plans. He had been treated with an antidepressant and started on Lithium, on 8.7.22, to try and reduce suicidality. His admission was informal, and he was allowed unescorted leave throughout his admission. On 16.7.22 he left the ward at 13.30 hours, and did not return. The ward staff were not aware that he had not returned until the nurse in charge was notified that he could not be found at 16.27 hours on that day. There were reports that he had been seen on the ward by a Health Care Assistant at 14.30 hours, and that he was in his bedroom at 15.30 hours. These reported sightings of him were not substantiated, and were incorrect. Detailed findings as to how he came by his death are described within a written Determination dated 4.8.23, appended to this report
5	**<u>CORONER'S CONCERNS</u>** 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 **MATTERS OF CONCERN** are as follows –

	1. There was a limited risk assessment and risk management plan documented for Gerard on ward B2 now Beech ward 2. There was an inadequate door board system for monitoring the return of patients after unescorted leave on ward B2. The same arrangements remain currently, despite the ward move to Beech ward on new premises 3. There was extremely limited family and carer involvement in Gerard's care, with no involvement in the care plan, nor involvement in ward rounds on ward B2 now Beech ward 4. There was limited awareness of the ligature risk reduction pathway by staff on B2 now Beech ward I am not reassured that necessary actions to address these serious issues identified are in place.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe you 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 **27th October 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: 1. Gerard's family 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.