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 [redacted], CEO Portsmouth Hospitals University NHS Trust** **2 [redacted], CEO Solent NHS Trust** **3 [redacted], CE NHS England**
1	**CORONER** I am Robert SIMPSON, Assistant Coroner for the coroner area of Hampshire, Portsmouth and Southampton
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 08 January 2020 I commenced an investigation into the death of Jack FARRINGTON aged 26. The investigation concluded at the end of the inquest on 27 July 2023. The conclusion of the inquest was that: On the 2nd January 2020 Jack Farrington died as a result of falling from a bridge. At the time, Jack was detained under section 2 of the Mental Health Act due to recent psychotic episodes. Evidence suggests that Jack's capacity to make rational decisions was severely compromised. When Jack was lucid he demonstrated a desire to be well and actively sought medical assistance for his condition. In the days prior to his death Jack had voluntarily attended hospital via ambulance. During Jack's time in hospital, he was able to abscond twice, and was sectioned under the Mental Health Act and transferred to a mental health facility. Following a suspected medical emergency Jack was transported back to hospital under escort. Significant failings in the assessment, recording, sharing of information, accountability and implementing appropriate measures to keep Jack safe contributed to his ability to abscond a third time, resulting in Jack's death.
4	**CIRCUMSTANCES OF THE DEATH**

	Jack Farrington had a long history of mental health difficulties. He moved to Hampshire in 2019 and his mental health started to deteriorate again later that year. He sought help from his GP and the community mental health services. On the 30th December he called an ambulance in a state of acute distress. He was transported to Queen Alexandra Hospital, Portsmouth (QAH) and assessed in the emergency department (ED). He was moved to the observation ward and seen by a consultant who requested further assessment to determine whether Jack needed to be detained under the Mental Health Act. Before this happened, Jack absconded from the observation ward via the fire door at approximately 9.00am. Jack was located by the police and returned to the ward where he was detained under s.5(2) of the Mental Health Act. He was subsequently detained under s.2 of the Mental Health Act. On the 31st December 2019 Jack absconded via the same route despite being under 1:1 supervision by a registered mental health nurse. Jack was located and returned to the ward by the police. In the early evening of the same day Jack was transferred to St James' Hospital and admitted to the Hawthorn ward. On the 1st January 2020 Jack threw himself at a glass dividing wall. On the 2nd January 2020 Jack suffered a medical episode and was transferred by ambulance to the emergency department of QAH. He was accompanied by 1 escort from St James' Hospital and remained within the ED awaiting medical assessment and treatment. At approximately 10.00am Jack ran from the ED and shortly after this fell from a road bridge sustaining fatal injuries.
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) <u>NHS England</u> Jack moved from Shropshire to Hampshire in the year leading up to his death. He had been under the care of the Midlands Partnership NHS Foundation Trust for many years in relation to his mental health difficulties and they held significant

records. He was assessed as stable in 2019 when he moved to Hampshire and was discharged from their service. When Jack became unwell again neither the community mental health team nor the in-patient mental health team of Solent NHS Trust were able to access Jack's records from the Midlands and a copy had to be requested. For a number of reasons this was not available prior to Jack's death and this may have impacted the decision making ability of the staff caring for Jack.

I heard evidence that there is no systems or arrangements for the sharing of access to electronic medical records (such as SystmOne and RIO) outside of local areas and the Care and Health Information Exchange (CHIE) operating in the local area contains limited information.

I also received evidence that the new NHS England National Record Locator system only acts as a flag to show who holds records rather than allowing access to clinicians.

This fragmentation of patient records means that medical and mental health practitioners do not have quick access to relevant information about their patients. In Jack's case he was detained under the Mental Health Act on New Years Eve and at the start of a bank holiday weekend. As such the staff of the mental health unit did not have any way to obtain his records during the out of hours period.

<u>Solent NHS Trust</u>
I am pleased to hear that since Jack's death and the subsequent inquest Solent NHS Trust have updated their training and guidance to staff members who are escorting detained patients. Additionally they are introducing an alert system within SystmOne for patients at increased risk of absconding and/or self-harm.

There remain 2 areas of concern:

1. Handovers

I heard evidence that the staff within the secure mental health unit rely very heavily on information given at handovers at the start of a shift and they do not have time to review the patient records in detail. At the time of Jack's death records of these handovers were not stored in the same way as other patient records and, in Jack's case, were missing entirely. This significantly hampered the investigation and inquest.

I am pleased to hear that Solent NHS Trust have now changed their document storage policy in this regard and these records will now be added to and stored on SystmOne.

However the handover records are not currently completed within SystmOne. This gives rise to the continuing risk of this information not being correctly recorded or correctly stored. I understand that this requires a change to SystmOne which is not yet complete.

2. Paper & electronic records
Solent NHS Trust still relies on paper forms for some observations and record keeping within the mental health unit. In Jack's case these were not scanned and stored which hampered the investigation and inquest. There remains a risk that where paper records are kept information is not properly recorded, stored or audited.

<u>Portsmouth Hospitals University NSH Trust</u>
1. Handover on arrival
I heard that there is no specific structure in place at Queen Alexandra Hospital Emergency Department for ensuring the full and accurate handover of information about a patient who arrives whilst subject to detention under the Mental Health Act. I heard evidence that the receiving staff are not required to ask about a patients history of absconding or self harm. This gives rise to the possibility of a patient's risk not being properly assessed. It was accepted in evidence at inquest that the hospital has a duty of care for all persons on it's premises and not just those who have been formally admitted as patients. In written submissions after the inquest hearing the hospital have stated that risks of absconding and self-harm are managed by the escorting mental health team. This does not, in my view, absolve them of responsibility for managing these risks whilst the patient is present at their site.

2. Flagging of risk
I heard in evidence that it is possible for patient risks to be 'flagged' within the Oceana records system to ensure that all staff are made aware of these. This was not done in Jack's case and that this was not done as a matter of course, The Acting Medical Director was not aware of an established policy or procedure about using this existing functionality.

3. Risk assessment tool
A 'Mental Health Primary Disturbance Survey' tool was used to assess Jack on his arrival at ED. This indicated that his risk level was 'level 5+ black' and this in turn set out a requirement of the mandatory presence of security guards. However when Jack absconded there was evidence that no security guards were present. There was evidence that clinicians made risk based decisions that such guards were not necessary.

However I heard evidence that the hospital board were not aware of this tool mandating a security presence and that the tool outcomes were not reflected in trust policies about the risk of absconding. The Acting Medical Director has stated that this tool requires assessment as to whether it is fit for purpose.

4. Paper and electronic records
There were records kept during Jack's presence at Queen Alexandra Hospital which were either not stored or had been lost prior to the inquest. This

	significantly hampered the investigation and restricted the information available to the jury. I accept that the location of patients with mental health issues whilst awaiting transfer to a mental health unit has changed since Jack's death. I also understand that mental health nursing records are now kept within an Enhanced Care Plan but this is still in a paper format and therefore the risk of inadequate information sharing and failing to store records remain.
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 November 09, 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 **The family of Jack Farrington** I have also sent it to **Midlands Partnership Foundation Trust** **Equans** 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: 14/09/2023**  **Robert SIMPSON** **Assistant Coroner for** **Hampshire, Portsmouth and Southampton**