Regulation 28: Prevention of Future Deaths report

Luke Mervyn WHITELAW (died 17.03.2023)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted]** **Chief Executive** **Oxleas NHS Foundation Trust** **Pinewood House** **Pinewood Place** **Dartford** **Kent** **DA5 7WG**
1	**CORONER** I am Ian Potter, assistant coroner, for the coroner area of Inner North London.
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 4 April 2023, an investigation was commenced into the death of LUKE MERVYN WHITELAW, then aged 46 years. The investigation concluded at the end of an inquest, heard by me, on 24 November 2023. The conclusion of the inquest was suicide, the medical cause of death being: 1a drowning
4	**CIRCUMSTANCES OF THE DEATH** (1) Mr Whitelaw had was known to mental health services at Oxleas NHS Foundation Trust prior to his death. (2) He was detained by police for his own safety, using their powers under section 136 of the Mental Health Act 1983, on 7 January 2023 having twice attempted suicide on that day. Having been treated in hospital (predominantly for his physical health as a result of the suicide attempts) between 7 – 12 January 2023, he was thereafter admitted to the Shrewsbury Ward in Oxleas House on an informal basis for care and support in relation to his mental health. He was discharged to the Greenwich Home Treatment Team, following an assessment by them on 25 January 2023.

	(3) His mood and mental health deteriorated significantly in late-January and early-February 2023. This deterioration was documented and noted by numerous individual clinicians, but they focussed on Mr Whitelaw's presentation in the moment, without reference to past notes or full consideration of past risk factors. (4) On 2 February 2023, Mr Whitelaw was seen by a psychologist. During the appointment he disclosed that he would be willing to accept a further informal admission to hospital. At the conclusion of that appointment, the psychologist made a verbal referral of Mr Whitelaw to another clinician for urgent medical review by a psychiatrist. That referral was not acted on and, as such, Mr Whitelaw was not re-admitted to hospital on an informal basis, or otherwise. (5) On 14 February 2023, Mr Whitelaw's wife reported to the police that Luke Whitelaw was missing. A missing person investigation was conducted. (6) On 17 March 2023, the Marine Policing Unit responded to reports of a body in the river Thames. They recovered a body, which was subsequently identified as Mr Luke Whitelaw.
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 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) Mr Lockwood's re-admission to hospital was indicated as early as 2 February 2023; however, he was not re-admitted to hospital, informally or otherwise. (2) A verbal referral was made for Mr Whitelaw to be urgently reviewed by a psychiatrist following the appointment on 2 February 2023, but not acted on. (3) The Oxleas NHS Foundation Trust's Serious Incident Investigation Report, dated 8 September 2023, identified numerous matters and learning points, including, but not limited to the following: • There had been a lack of "professional curiosity" in the assessment and planning of Mr Whitelaw's care and treatment • "Discussions and assessments of risk should be clearly documented" • "Risk formulations should consider both current and historic/contextual risks and incorporate ratings of mood to ensure that these are not used in isolation and are linked with appropriate interventions" • There were "missed opportunities identified in relation to LW's self-reported deterioration following his discharge from hospital which do not appear to have been fully explored." However, the Serious Incident Investigation Report does include any plan to address the concerns it identified. As such, there

	insufficient reassurance that there is plan to address the matters in a meaningful way moving forward.
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 22 January 2024. 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: (a) [redacted] (Luke Whitelaw's wife) (b) [redacted] (Luke Whitelaw's sister). 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	**Ian Potter** **HM Assistant Coroner, Inner North London** **27 November 2023**