REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **CEO, Frimley Health NHS Foundation Trust (FPH)** 2. **CEO, Surrey and Borders Partnership NHS Foundation Trust (SABP)**
1	**CORONER** I am Darren Stewart OBE, 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 2009and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 4th April 2018 I commenced an investigation into the death of Ryan John EVANS. The investigation concluded at the end of the inquest on 23rd January 2023. The inquest was heard with a Jury. Mr. EVANS died of: 1a: Asphyxia 1b: Suspension by the neck The jury returned the following narrative conclusion: Narrative conclusion Ryan John Glyn EVANS was a 20 year old man with a global learning delay (a learning disability) and was registered disabled. He had a diagnosis of depression which dates back to 2016. He was physically fit and was living on his own in assisted living with seven hours of support a week. Ryan was adopted at age two along with his older brother and sister and were brought up in a close family unit with his adoptive parents, following a traumatic early childhood. Ryan was vulnerable due to his learning disability and depression, recent self-harm and attempts of suicide. Ryan's mental health had deteriorated over approximately seven months due to a number of contributory factors. - Notice to leave his accommodation and uncertainty of future living plans. - Finding out the nature of his biological fathers suicide (hanging) via social media - Medication, drugs and alcohol - Breakdown in relationship with ACASA management

Ryan was arrested on 2nd April outside ACASA offices for:
-Outstanding criminal damage
-Threatening behaviour
-Violent / Abusive phone calls

Ryan was taken to Frimley Park Hospital by ambulance following collapse in the police van with chest and abdomen pain, his self-harm injuries were dressed and no physical issues were discovered so he was released into police custody. Despite evidence of self-harm, no Mental Health Assessment was carried out at this point.

On booking into police custody, Ryan was noticeably upset. He was referred to and visited by a Health Care Professional (HCP) and Hampshire Liaison and Diversion Service (HLDS) at the request of the police custody sergeant.

-HCP reviewed his physical condition and redressed his self-harm injury
-HLDS failed to document the encounter on the RIO system and only updated the custody record with a screening document.

This follows a failure to update the RIO system in January 2018 when Ryan was previously seen by HLDS.

There was failure to carry out a Mental Health Assessment and no record of Ryan refusing to be assessed. It could not be concluded that these shortcomings significantly shortened Ryan John Glyn EVANS life.

HLDS report screen was completed and uploaded onto the custody record with no reference to a Mental Health Assessment being required or declined by Ryan.

Throughout Ryan's stay in custody he expressed suicidal ideations on multiple occasions, spoke to the Samaritans and concerns were raised by family which were reported back to the custody Sergeant. Communication of this information was ineffective. Additionally, across the custody suite there was a sense of complacency with references to Ryan's behaviour being "attention seeking" and no future referrals to HLDS were made. Despite no formal guidance, it is regrettable that on disposal, no verbal handover was done with Ryan's father. It could not be concluded that these shortcomings significantly shortened Ryan John Glyn EVANS life.

Ryan was released into the care of his father at approximately 22:30 from Basingstoke Custody Centre. He was in a distressed state over the conditions of his discharge and how he found out about his biological father committing suicide by hanging.

Ryan refused to go home to his parents residence and wanted to go to his own accommodation. His father dropped him off around midnight and waited till Ryan was safely in the building.

Ryan was found hanging the following morning, 3rd April 2018, by a fellow resident in the communal area of the building.

Ryan had a long standing history of depression and several suicide attempts.

	Ryan John Glyn EVANS took his own life while suffering from the diagnosed medical illness of depression.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are recorded in the Jury's Narrative Conclusion.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. The concerns raised were as follows: a. Referral to Psychiatric Liaison Services for patients presenting with self-harm injuries and suicidal ideation (including those in Police custody) at Frimley Park Hospital A&E, including the extent to which the NICE guidance is complied with or provides effective guidance to staff in such circumstances. b. The conduct of Mental Health Assessments in a custody setting by liaison and diversion staff including the adequacy of policy and guidelines relating to triggers to conduct such assessments and the manner in which refusals are dealt with. c. The passage of information both between custody staff, as well as with healthcare staff in relation to concerns of a mental health nature for a detained person including the extent to which the custody record is used as an effective means to communicate concerns/observations of detained persons mental health. d. The process of release of a vulnerable detained person following disposal, including interaction with family or other persons collecting the detained person. I received further evidence in writing from the Interested Persons' subsequent to the completion of the Inquest in relation to these concerns. This evidence included responses from Hampshire Constabulary and Southern Health NHS Foundation Trust concerning the measures which have been put in place to address the failures identified during the course of the Inquest with respect to concerns at b – d (above). I was satisfied that these measures addressed the concerns in relation to each of these Interested Persons. I also received evidence from the Frimley Health NHS Foundation Trust concerning the measures which that organisation had undertaken in their area of responsibility to address my concern detailed at a (above). **This evidence has not allayed my concern in relation to a (above).** 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. Evidence received from the police officers accompanying Mr. EVANS during his attendance at Frimley Park Hospital provided that: a. Mr. EVANS presented with a large fresh cut on his arm and also cuts on his

legs which were identified by him as being from self-harm with hospital staff noting that the larger mark on the arm might require stitching.

b. Police officers stated that Mr. EVANS was open with hospital staff about his feelings of self-harm depression, and thoughts of ending his own life. Officers further recalled that hospital staff noticed and commented on the self-harm marks on Mr. EVANS' arms, including whilst staff were dressing a recent self-harm wound on Mr. EVANS' left arm.
c. Officers also recalled Mr. EVANS commenting when offered food by hospital staff that he would rather starve to death.
d. One of the accompanying police officers expressed surprise at the fact that Mr. EVANS was not subject to a mental health referral or assessment, in the context of him commenting to multiple hospital staff members about his self-harm actions and ideation.

An emergency department consultant at Frimley Park gave evidence which suggested that no mental health assessment was or would have been necessary where Ryan's presenting complaint was recorded as chest pains rather than of self-harm and/or suicidal ideation. Although self-harm had been noted in the records, no explanation could be provided for why Ryan's suicidal ideation had not been recorded.

The consultant was further questioned in relation to the 2006 NICE Guidelines "Self-Harm: The short term physical and psychological management and secondary prevention of self-harm in primary and secondary care" which are national guidelines that ought to feed into practice at the hospital.

These guidelines provide that "Following triage patients who have self-harmed should receive the requisite treatment for their physical condition, undergo risk and full psychosocial needs assessment and mental state examination, and referral for further treatment and care as necessary" and "All people who have self harmed should be offered an assessment of needs, which should be comprehensive and include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness, as well as a full mental health and social needs assessment."

Evidence received during the course of the Inquest was not able to reconcile the contradiction between the NICE guidelines on self-harm and Mr. EVANS having had no mental health assessment despite obvious signs of self-harm and further evidence of disclosure of suicidal ideation.

The jury in their Narrative Conclusion found that 'Despite evidence of self-harm, no mental health assessment was carried out at this point.'

I remain concerned as to how such a situation would be avoided if a patient presented again in similar manner to Mr. EVANS. The additional evidence on PFD matters provided by Frimley Health NHS Foundation Trust does not refer to or address the NICE guidelines on self-harm or explain what would now be done differently were a patient such as Mr. EVANS were to be seen again.

The Frimley Health NHS Foundation Trust additional evidence refers to matters being in the process of introduction and new referral criteria with Surrey and Borders Partnership NHS Foundation Trust, but this does not explain how this would prevent the future risk of a patient such as Mr. EVANS leaving the hospital without a mental health assessment.

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 29th February 2024. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting outthe 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 namely: Family of Ryan John Glynn EVANS Hampshire Constabulary [redacted], Hampshire Constabulary [redacted], Hampshire Constabulary Southern Health NHS Foundation Trust [redacted] Former SHFT Employee, Registered Mental Health Nurse MITIE [redacted], Former MITIE Employee, Health Care Practitioner (HCP) Alexander's Care and Support Agency (ACASA) IOPC I may also send a copy of your response to any other person who I believe may find ituseful 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 usefulor 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.
9	**20th December 2023** **Darren Stewart OBE**