REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

[redacted], Chief Executive
West Hertfordshire Hospitals NHS Trust
Watford General Hospital
Vicarage Road
Hertfordshire
WD18 0HB
[redacted]

1	CORONER I am Mr P.A. Murphy, Area Coroner for the coroner area of the Northern District of Greater 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 the 3rd of December 2021 an investigation was opened into the death of Mr Paz Ogbe-Millar. On the 4th January 2022 an inquest was opened, which concluded at a final hearing before me on 21 October 2022. The conclusion of the inquest was that Mr Ogbe-Millar intentionally took his own life by jumping in front of a moving train while suffering from a relapse in cannabis induced psychosis and that this outcome was contributed to by the following factors: (a) The decision by the Community Mental Health Team to discharge Mr Ogbe-Millar from its service on 30 November 2021; (b) The absence of an adequate system at the Emergency Department to record information provided by the police to the hospital staff regarding Mr Ogbe-Millar's risk of self-harm; (c) The decision by the Emergency Department not to allow Mr Ogbe-Millar's mother to remain with him in the hospital, pending the arrival of the Mental Health Liaison Team; (d) Problems surrounding the system for making referrals to the Mental Health Liaison Team; (e) The decision of the Emergency Department not to go outside with Mr Ogbe-Millar when he said he was going outside to smoke after his mother was required to leave.

4	**CIRCUMSTANCES OF THE DEATH**

Mr Ogbe-Millar died on 2 December 2021. He was 30 years old and described by his mother as highly intelligent, articulate, charming and well read. For much of his life Mr Ogbe-Millar was a heavy cannabis user, which led to his diagnosis with cannabis induced psychosis in 2020.

Mr Ogbe-Millar received treatment from community and in-patient mental health teams at various stages, including two hospital admissions under the Mental Health Act 1983 in late 2020 and in early 2021.

On being discharged from hospital in March 2021 he enjoyed a period free of cannabis and psychosis. He was able to work, attend Narcotics Anonymous and come off his medication. This led to his discharge from the community mental health team in June 2021.

In November 2021 Mr Ogbe-Millar gave up his job and resumed using cannabis on a daily basis leading to a relapse of his mental illness. His mother sought help from the community mental health team who spoke to Mr Ogbe-Millar by telephone on 26 November 2021 and referred him to a substance abuse organisation, which did not specialise in psychosis. He was discharged by the community health team on 30 November 2021, without the team having obtained any information regarding his relapse from his mother.

In the early hours of 2 December 2021, Mr Ogbe-Millar sent a text message to his mother saying: "I'm sorry for my actions and I hope you all find peace". His mother immediately telephoned the police, who found Mr Ogbe-Millar at home, [redacted]

The police took Mr Ogbe-Millar to the Emergency Department of Watford General Hospital, which is operated by West Hertfordshire Teaching Hospitals NHS Trust ('WHTHNT') where there was an inadequate system for recording the information provided by the police to the hospital concerning his risk of self-harm.

Mr Ogbe-Millar was assessed by hospital staff later that morning as a moderate risk of self-harm and told to await the arrival of the local Mental Health Liaison Team, which is operated by the Hertfordshire Partnership University NHS Foundation Trust ('HPUNFT')

Despite Mr Ogbe-Millar's risk of self-harm and the protective factor provided by the presence of his mother, she was not allowed to stay with him at the Emergency Department while he waited for the Mental Health Liaison Team. Instead, she was required to leave by staff in breach of hospital policy.

The Mental Health Liaison Team had not arrived to assess Mr Ogbe-Millar by the time his mother was required to leave the hospital due to problems surrounding the referral system.

Soon after his mother had been required to leave, Mr Ogbe-Millar left the Emergency Department unaccompanied saying he was going outside to smoke a cigarette.

He never returned and instead travelled to London, where he died after jumping in front of a high speed train at Harrow and Wealdstone train station at 10.09pm on 2 December 2021.

5 **CORONER'S CONCERNS**

The MATTERS OF CONCERN are as follows. –

a. Evidence was heard regarding the appropriate level of observation by Emergency Department staff of mental health patients waiting in the Emergency Department (operated by WHTHNT) to be seen by the Mental Health Liaison Team (operated by HPUNFT). There was confusion amongst the WHTHNT witnesses as to the appropriate level of observation. This was contributed to by a lack of clarity in WHTNHT's (a) Standing Operating Procedure entitled: "Management of Mental Health Patients in the Emergency Department (ED) at Watford General Hospital (WGH): Standing Operating Procedure ('SOP'), Issue date August 2021"; when compared with (b) WHTNHT's "Emergency Department Adult Mental Health Pro-forma" Version 3, Undated ('EDP');

b. The SOP states in a section titled "5. Procedure" (on page 4 of 16☺ "Patients at moderate or high risk of self-harm or of leaving before assessment and treatment should be observed closely whilst in the ED. There should be continuous observation, and this should be documented in the mental health presentation engagement record (Appendix 1);

c. Whereas the EDP states at page 7 under the heading: "Summary of levels of risk and suggested action", the following:
"Low: No special observations required
Medium: Consider 15-minute special observation";

d. Emphasis has been added above to paragraphs (b) and (c) in bold text;

e. My concern is that the inconsistency between these two documents creates a risk that mental health patients at medium risk of self-harm awaiting assessment for their mental health condition in the Emergency Department may not be subjected to an appropriate level of observation.

ACTION SHOULD BE TAKEN

I provided WHTHNT's solicitors with an opportunity to supply any information relevant to the concerns set out in this report during and after the inquest. My understanding is that the relevant parts of the policy guidance which have caused me concern remain in place.

In my opinion, action should now be taken to prevent future deaths, and I believe that your organisation has 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 2 April 2024. I, the Coroner, may extend this 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 solicitors of the Interested Persons in the inquest proceedings: [redacted] I am also under duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive that response. I may also also send a copy of your response to any other 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	Signed: Tony Murphy Mr PA Murphy Area Coroner Northern District of Greater London Dated: 5 February 2024