REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive, Central and North West London NHS Foundation Trust. [redacted] Commissioner of the Police of the Metropolis [redacted] Chief Executive, NHS England
1	**CORONER** I am Professor Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West 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** From the 22nd January until 1st February 2024, evidence was heard before a jury touching the death of Mr Roberto Bottello. He had died on the 16th September 2020, aged 44 years. **Medical Cause of Death** 1 a. Multiple Injuries **How, when, where and in what circumstances the deceased came by his death:** Roberto Bottello had been suffering problems with depression, anxiety and panic attacks in the months leading up to his death. On the 25th August 2020 he attended the urgent care centre at Hillingdon Hospital presenting with sleeplessness and visual hallucinations. He was referred to the psychiatric liaison nurse and discharged to be followed up by Addiction Recovery Community Hillingdon (ARCH). This referral was followed by 2 GP referrals and a self referral, He was not seen or assessed by ARCH prior to his death. Over the 13th and 14th of September 2020, Roberto presented to police officers on 4 occasions, presenting with paranoia. These presentations resulted in 3 Merlin reports of Adult Come to Notice made by police, which were on Roberto's psychiatric record by 15th September 2020. Roberto's last contact with his family was a telephone call on 14th September 2020. At around 21:00 on 14th September Roberto's mother called the Single

Point of Access (SPA) and was advised to report him missing. His parents reported Roberto missing to police at around 10:00 on 15th September 2020, and a missing person report was made.

Roberto came to the attention of police when he was in Berkely Square, London at around 00:10 on 16th September 2020. He was acting in an acutely disturbed manner. Hs body was tense, he was grinding his teeth and largely unresponsive. He had no shirt or shoes on. He began screaming at the sky. The police officers suspected ABD/ excited delirium. Roberto charged at the police officers. One officer pushed him back with an open hand and both officers challenged him with their taser red dot. He then became calm again. Further police officers and an ambulance attended Roberto.

After further agitation, Roberto was placed in handcuffs, place in an ambulance, and then his legs were placed in restraints. He was detained under section 136 of the Mental Health Act (MHA) and was transported to St Mary's Hospital by ambulance.

At hospital, Roberto remained under guard by 2 police officers. The police liaise with the SPA to try to find a s.136 suite for Roberto. Roberto was medically cleared by 03.20 by the Accident and Emergency (A&E) doctors and he was referred to psychiatric liaison at 03.26. The differential diagnosis at the time of referral to psychiatric liaison was that Roberto was not intoxicated and was experiencing an acute psychotic episode. Roberto was seen by psychiatric liaison at 03.55 and referred to the psychiatrist for a MHA assessment at 04.34. A place was made to defer the MHA assessment until after 09.00. The deferral of the assessment was reasonable based on his presentation and past history as known to the psychiatric team at the time.

Roberto's identification was unclear to the police in the hospital, the SPA agents and hospital staff. Inadequate steps were taken to identify Roberto until his identity was established by the psychiatric liaison nurse prior to 04.34. Identification details were passed to police at the hospital but there were missed opportunities to clarify his identity, especially in the final call between police and the SPA. The SPA and Hillingdon bed manager made assumptions about his identity.

If a s.136 suite had been made available to Roberto he would have been transferred but there is uncertainty about whether he would have been transferred before the time at which he fell from the window.

The SPA asked police officers to contact bed managers in an attempt to secure a s.136 suite for Roberto, against the policy at the time that the SPA find the suite.

At the time of the incident that led to his death, Roberto was in cubicle 5 in St Mary's Hospital. 2 police officers and one emergency departmental lead registrar were with him.

At around 06.00 Roberto began to show agitation again. An A&E nurse was dismissive about his behaviour. At around 06.20 he took his remaining clothes off and also took his medical stickers off. He was spoken to by the police officers who asked him if he wanted to go to the toilet. An officer called a doctor to help who entered cubicle 5 with the officer.

They tried to calm Roberto and talk to him. He became more agitated. A police officer asked him to move back on the bed.

Roberto started rocking on the bed, which was level with the windowsill. He put his foot on the sink and rolled himself backwards and moved himself onto the sill. He kicked the window and broke the glass. He moved himself backwards through the window. He was cut by broken glass as he exited the window. He fell 25 feet to the canal path below.

Roberto's state of mind at the time, insofar as it may be determined, was that he was psychotic and in a state of agitation. He would not have acted as he did if he had not been psychotic.

After Roberto exited the window, there was a short delay before medical staff reached him because a gate was locked. He was attended by medical staff and the two police officers on the canal path.

As a result of the incident, Roberto suffered injuries:

- cuts, bruises and grazes;
- injuries to his limbs;
- his lift upper limb suffered a large cut and his axillary vein and artery were divided;
- he lost a large amount of blood; and
- both of his lungs collapsed

Roberto was given CPR. He was administered adrenalin and regained a pulse. He was given a bilateral theracostomy. The trauma surgeon was alerted at 06.31. Roberto was transferred from the canal path to the emergency department. He proceeded directly to the surgical department. His blood vessels were clamped. He was given a blood transfusion. He lost circulatory output. He was given further CPR and shocked twice. He had minimal heart function and suffered cardiac arrest. His heart rhythm had become incompatible with life.

Roberto Bottello's death was announced at 07.27 on 16th September 2020.

Matters which may have possibly caused or contributed to Roberto Bottello's death:

The following matters may have possibly caused or contributed to Roberto's death:

Cubicle 5 in which Roberto was placed in hospital was inadequate and unsuitable because it was a rm with windows rather than a designated mental health cubicle, and the bed was next to the windowsill and at the same or similar level. There were no effective measures in place to prevent patients breaking or exiting through the windows, notwithstanding that the windows were compliant with the legal requirements at the time.

	There was insufficient communication between various parties involved, including: - The SPA and police; - A&E and the psychiatric liaison team; - Psychiatric liaison team and police; - Within the psychiatric liaison team; - The Hillingdon bed manager and the SPA and Central Flow Hub; and - The Hillingdon bed manager and the police. The information management systems involved were inefficient and inadequate. Roberto was not cared for by a Registered Mental Health Nurse (RMN) but was cared for by police officers, who are not mental health specialists. There was insufficient RMN provision at the time. An RMN would have been better placed than police officers to monitor Robert's mental state, identify any issues such as increased agitation and developing risks. The confusion of Roberto's identity with a patient who had just been discharged from Hillingdon and the section 136 suite being made unavailable to him. The apparent lack of available s.136 suites. **Conclusion of the Jury as to the death:** Roberto Bottello was experiencing an acute psychotic episode. He was detained under s.136 of the Mental Health Act. he broke the window of his hospital cubicle with his feet and exited the window falling to the canal path below. In doing so, he suffered multiple injuries including cuts from broken glass that divided his axillary vein and artery and led to his death.
4	Extensive evidence was taken during the inquest from multiple live witnesses, written statements, reports, body worn footage and recordings of telephone calls between the police and SPA. Please see the extensive findings made by the jury in this case as set out above. Of relevance to this report: It was clear from the evidence that SPA were asking police officers to ring around various s. 136 suite providers to try and find a space for him, against policy at that time. That a suite was available in Hillingdon that had not been declared as vacant as it should have been against policy. That this space should have been made available to Roberto and it was not against policy. This meant that the Central Flow Hub advised the psychiatric liaison nurse that there were no spaces available in London and as such the psychiatric liaison nurse drew up management plans that centred on getting Roberto's required Mental Health Act assessment undertaken by the psychiatric liaison team, which is often slow and difficult to arrange, rather than having the option to consider transferring him more promptly to a section 136 suite. That identification assumptions were made by the Hillingdon Bed manager and SPA based solely upon his sex and a similar first name to a person who had been discharged earlier in the day by Hillingdon that the person discharged was Roberto.

This identification assumption could have been easily put aside even with the minimal identification evidence being sought, but staff at Hillingdon, and SPA did not do this. On this basis Roberto was refused a space in Hillingdon against policy, which he should have been allowed access to, even if had been the person with whom he had been confused who had just been discharged.

SPA staff colluded with the actions of the bed manager even though they knew it was against policy.

Simple identification checks that could have been made were not.
For example using the international phonetic alphabet in relation to Roberto's surname in communication between police and SPA staff, and relying on numeric date of birth rather than using the name of the month. Both police and SPA staff did this which caused delay in identification.

The manager of SPA and Central Flow Hub at the time stated that she was completely unaware that staff were acting against training and policy.

The court had experienced immense difficulty in getting evidence from CNWL in relation to the Hillingdon issues despite repeated requests, such that the evidence was not clarified until the last day of evidence and after further directions had been give live in court. This was in my view a failure of the duty of candour by CNWL.

The court was grateful to the current senior manager from CNWL who worked over the weekend to secure the evidence that the court had been requesting for years.

It was also clear to the court and jury that the evidence of SPA witnesses was at times not credible despite recordings of the calls they made and transcripts of these calls being used as part of the evidence.

There were clearly issues in relation to communications at all levels as set out by the jury.

There were obvious errors made by SPA staff in relation to how they search their computer systems to identify individuals.

Together these matters meant that a section 136 suite was not made available to Roberto that should have been and it was possible that this contributed to his death.

The psychiatric liaison nurse did not share the assessment and differential diagnosis made by the A&E doctors with the psychiatric registrar. This was especially poignant in this case as it became clear that Roberto was not intoxicated at the time and was psychotic, rather than his symptoms being due to acute intoxication with drugs and/or alcohol as was assumed by the psychiatric liaison nurse and passed to the psychiatric registrar. The A&E doctor had diagnosed Roberto correctly some hours before his death and medically discharged Roberto. This was recognised by the psychiatric registrar, who is now a consultant, as a point of learning for her and psychiatric liaison.

All witnesses confirmed that there are at times still shortages of section 136 suites and heavy demand from psychiatrically unwell people despite definite improvements in service.

Further that most s136 incidents occur out of hours when there is less resource to manage them from psychiatric services.

Evidence from the psychiatric doctor was that there are severe resource shortages in the area in which she now works with up to 50% of psychiatric nursing staff posts being vacant.

	There is now direct access by police on many occasions to section 136 suites within London, a practice that could be adopted nationally, with general improvement in service provision. Extensive evidence was taken in relation to the window through which Roberto had exited to his death. This window was consistent with building regulations but film has now been applied by Imperial to windows in situations where disturbed persons may be more at risk of smashing them to make these windows more difficult to smash and if they do, then be less likely to shatter and cause lacerations.
5	**Matters of Concern** 1. That CNWL failed in its duty of candour in relation to provision of evidence in this case. 2. That the evidence given by the SPA witnesses was at times not credible. 3. That SPA call handlers were not sufficiently trained in how to identify patients by using computer searches and by not seeking information appropriately for example by using the international phonetic alphabet and using the word for the month in a person's date of birth. 4. That police officers may need reminding to use the phonetic alphabet and using the word for the month in a person's date of birth. 5. That CNWL were and may still be unaware that CNWL staff operate outside policy. 6. That the psychiatric liaison nurses and psychiatric liaison doctors should have regard to and specifically consider diagnoses made by other doctors for example those who see such patients repeatedly in A&E as in this case. 7. That most section 136 usage is out of hours when there is less resource to respond from psychiatric services. 8. That other areas in England could learn from how section 136 suite access has been restructured in London. 9. That the use of film over glass in areas where patients are at increased risk of smashing windows should be more widespread in the NHSE estate. 10. That there are continued shortages in psychiatric care provision.
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. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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: Father of Mr Bottello [redacted] [redacted] Chief Executive, Imperial Health Care Trust . IOPC 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	**16th February 2024**  **Professor Fiona J Wilcox** **HM Senior Coroner Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED** **Inner West London Coroner's Court,** **33, Tachbrook Street,** **London.** **SW1V 2JR** **Telephone:0207 641 8789.**