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 Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust 2 The Rt Hon Victoria Atkins MP, Secretary of State for the Department of Health and Social Care 3 Chief Executive, NHS England 4 Chief Executive, OFCOM
1	**CORONER** I am Michael WALL, Assistant Coroner for the coroner area of Nottingham City and Nottinghamshire
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 11 May 2022 I commenced an investigation into the death of Daniel Mark Edward TUCKER aged 24. The investigation concluded at the end of the inquest, conducted before a jury, on 06 February 2024. The jury returned a narrative conclusion.
4	**CIRCUMSTANCES OF THE DEATH** Daniel (referred to as Dan at the request of his family) was detained pursuant to s.2 of the Mental Health Act 1983 on Saturday 9th April 2022 and admitted to Redwood 1, Highbury Hospital, Nottingham the following day. He had a diagnosis of Emotionally Unstable Personality Disorder (EUPD) and a long history of mental ill health, including multiple instances of self-harm and suicidal thoughts and behaviour. Following a period of relative stability, he presented at A&E on 5th April 2022 after an episode of deliberate self-harm. He disclosed suicidal thoughts. He was referred to the Crisis Resolution Home Treatment Team that day but was detained on 9th April after disclosing that he had not only an intention but a plan to end his life, details of which he declined to disclose. Due to previous negative experiences on Redwood 1, Dan requested a move to another ward. He declined nearly all attempts by staff to engage with him and was consistently described as low in mood, very withdrawn and largely confining himself to his bedroom. He was physically (though not formally) discharged following a Ward Round on 22nd April 2022. A clinical psychologist present at that Ward Round gave evidence that she raised concerns that his mental state and demeanour were not conducive to imminent discharge. Dan left Highbury Hospital at around 17:55 that day. At approximately 20:30, he ingested a lethal quantity of [redacted] which he purchased [redacted] prior to his detention and admission to Redwood 1. The jury found the following failings in Dan's care (the first four of which were admitted) contributed to his death:

	• More should have been done to try and effect the move from Redwood 1 to another hospital/ward in line with Dan's wishes. • There was a failure to allocate a Named Nurse and/or a failure of the allocated named nurse to carry out a 1:1 session with Dan during his admission. • There was a lack of exploration in the Ward Round on 22 April 2022 and/or a lack of documentation of an exploration in the Ward Round of the "plan" that Dan had to end his life before his admission. • There was a failure by ward staff to hand over information regarding a threat to ligate (noted in the handover sheet from 20 April 2022) to the Ward Round on the 22 April 2022. • A failure to record and take appropriate action following significant risk-related incidents (Daniel expressing an intention to self-harm) which occurred during Dan's admission. • A failure to take proper account of all available relevant information concerning Dan's risk when assessing his risk prior to discharge. The jury also found the following failings (the first three of which were admitted) but did not find these to have contributed to Dan's death: • A failure to update Dan's ward specific Care Plan and Risk Assessment documentation in RIO during his admission. • Dan had a Crisis Care Plan developed in August 2018 and updated in January 2019. There was a failure to update it in preparation for his discharge on 22 April 2022. • A failure to adequately discuss Dan's risk with Dan's carer prior to discharge. • A failure by the Trust to engage adequately with Dan's family and/or carers either during his admission on Redwood 1 and/or at the point of discharge. The inquest heard evidence that Dan had openly discussed his plans to end his own life on a chat forum of the [redacted] while detained at Highbury Hospital. It appears he also obtained information on [redacted] as a method of suicide and where to source it, from that site. [redacted]
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) The following matters of concern are directed to NHCT for response -

1. A continuing practice/culture of minimising the importance of a ward specific risk assessment and care plan

I am concerned that, notwithstanding the existence of a clear, appropriate policy and significant commendable actions by the Trust since Daniel's death to address this issue, there remain clinical and nursing staff who do not fully recognise or accept the importance of completing and utilising the required risk assessment and care plan. This suggests there may be a persisting training or cultural issue.

The inquest heard evidence that there was (and remains) a clear and robust policy in place which most staff were aware of. This requires a care plan and risk assessment be initiated upon a patient's admission, completed within 72 hours of admission and updated as necessary during admission. Further, since Dan's death, the Trust has gone to considerable and commendable lengths to ensure that care plans and risks assessments are in place in every case and to reinforce the requirements of this guidance within the Nursing team; that team hold primary (but not sole) responsibility for creating and updating the risk assessment and care plan document. I also heard that a recent audit found that all current patients had an appropriate care plan in place. The Ward Manager agreed this is "a basic and fundamental part" of any patient's care. In spite of all of this, an experienced ward nurse and two psychiatrists (a consultant and a registrar) involved in Dan's care seemed to minimise the practical importance of the required process and documentation, the latter both suggesting they would not routinely consult it.

2. Inadequate system of allocating a named nurse to patients and recording the same

I am concerned that, notwithstanding the existence of a clear, appropriate policy requiring the same, the current system of allocating a named nurse and ensuring patients receive regular and effective 1:1 sessions with them are inadequate. I am also concerned that no record is kept of the named nurse appointed to each patient, thus (as in this case) hindering any investigation where issue around the role and actions of that person arises.

The General Manager of Adult Mental Health at the Trust helpfully and frankly acknowledged that the evidence heard at inquest raised questions about the adequacy of the existing system, of which he was not previously aware of. It remains unclear whether Daniel was appointed a Named Nurse who failed to perform that role effectively, or whether there was a failure to appoint such a nurse at all. The General Manager's view was that under the existing system, it is possible that a named nurse was appointed without their knowledge. While the Ward Manager gave evidence that she would have no confidence Daniel would have known who his named nurse was, even if one was appointed. The inquest heard evidence that named nurse sessions with Daniel during previous admissions had been important opportunities for engagement with staff and had elicited a substantial amount of information pertinent to his risk and treatment. The General Manager assured me that he has already requested an urgent review of the system, but he was unable to provide any further information upon conclusion of the inquest as to what further action, if any, is proposed.

3. Inadequate skills/knowledge/training on how to encourage patients to engage

I am concerned that clinical, nursing and/or support staff may not currently have sufficient skills or knowledge in dealing with patients who appear unable or unwilling to engage with staff and/or treatment.

A psychiatrist not involved in Dan's care gave evidence about the advice he would have given to colleagues on how to seek to assist a patient who, like Dan, was unwilling or unable to engage with staff: first, identify the likely reasons for the patient's lack of engagement; second, having regard to those reasons, develop plans and strategies to address the specific barriers identified.

I heard little evidence that either of these steps was followed by any of the staff involved in Dan's care. One barrier was identified (his previous negative experiences on the ward and wish to be transferred to another ward or hospital) but seemingly forgotten after an initial transfer request to the Bed Management team, which was not then followed up. Even with the benefit of hindsight, the doctors, nurses and healthcare assistants involved in Dan's care seemed unable to offer any insight into the reasons for his difficulties engaging beyond his diagnosis of EUPD or articulate any strategies or techniques that might have helped him overcome them.

The following matters of concern are addressed to **Secretary of State for Health and Social Care & NHS England**

1. I am concerned that confirmed ingestion of [redacted] during a 999 call does not trigger a category 1 response from the Ambulance Service

Dan ingested [redacted] at around 20:30 on 22 April 2022. His friend informed the 999 call handler that he had done so during a first 999 call at 20:39. That call was correctly graded as requiring a category 2 response, as Dan was both conscious and awake. 14 minutes later, at 20:53, Dan collapsed. His friend's second 999 call was correctly graded as requiring a category 1 response, as Dan had become unconscious, his breathing agonal. The first ambulance crew arrived at 21:04. Dan went into cardiac arrest at approximately 21:24. Consideration was given by the ambulance crew to 'scoop and run' to arrange a rendezvous to administer the necessary "drugs to counter [redacted]", but this was no considered longer feasible once Dan had gone into cardiac arrest.

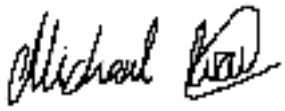
The inquest heard evidence from a consultant toxicologist that even in very small quantities [redacted] (or [redacted]) is lethal; it is a potent poison. I understand it is also, tragically, an increasingly common means of suicide. Mental health professionals who gave evidence expressed deep concern at its easy availability and growing popularity for vulnerable people seeking to end their own lives. The expert toxicological evidence indicated that its acute toxic effects can be rapid (as short as 20 minutes after ingestion, depending on dose) and can quickly become irreversible.

This suggests that almost any case involving the ingestion of [redacted] or [redacted] is likely to be a time critical life-threatening event. Yet it is does not currently fall within that category for the purposes of grading 999 calls, unless the patient is unconscious or not breathing. While there was no evidence that a category 1 response would have prevented Dan's death, I believe there is a risk that other deaths will occur if ingestion of [redacted] continues to require a category 2 response.

The following matters of concern are addressed to the **Secretary of State for Health and Social Care and the Chief Executive of OFCOM**

1. Continuing accessibility of [redacted]

Dan was using an online suicide forum, [redacted] Through that forum he was able to engage in discussions with other [redacted] members and obtain information [redacted]
Notwithstanding the provisions of the Online Safety Act 2023, and apparent attempts to block access to the website, I heard evidence that it remains easily accessible to vulnerable people in the UK. I am concerned that further deaths will occur while this remains the case.

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 27 April 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 1. Dan's family 2. East Midlands Ambulance Service 3. CQC 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: 29/02/2024**  **Michael WALL** **Assistant Coroner for** **Nottingham City and Nottinghamshire**