REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of 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 the 24th January 2023, I commenced an investigation into the death of Kenneth Stanley Baylis The investigation concluded at the end of the inquest on the 26th January 2024 The conclusion of the inquest was a narrative conclusion as follows: Mr Baylis took his own life on 23rd January 2023 whilst on unescorted leave, when he was an informal inpatient on Kingsley Ward of Millbrook Mental Health Unit. He had a history of depression, and repeated serious and escalating suicide attempts over a fourteen month period leading up to his death. His risk of suicide was real and imminent throughout his final admission from 28.12.22. This was not properly recognised by the treating team with responsibility for his care, due to a failure to involve his family in risk assessment and support and safety planning, a failure to follow procedures regarding unescorted leave for informally admitted patients, and a failure to properly weigh up all the relevant factors which contributed to suicidal risk. The decision on the 10th January 2023, to allow unescorted leave from the ward, was not an appropriate one. All these omissions in care made a more than minimal, negligible, or trivial contribution to his death
4	**CIRCUMSTANCES OF THE DEATH** Mr Baylis took his own life [redacted] on 23.1.23. He died from multiple injuries. He did so with the intention of his actions leading to his death. He made four previous serious and escalating attempts to end his life from November 2021, until finally succeeding on 23rd January 23 - this was despite caring support from his family and from many of the mental health professionals that he met both as an inpatient and when supported by the community teams. Sadly, however the building picture of increasing risk of suicide was not fully understood by the team on Kingsley ward. During Mr Baylis's final inpatient psychiatric admission, the seriousness and his intent to die, were significantly underestimated. There was inadequate risk assessment during this last admission, lacking in detail and incomplete. His repeated reporting of lack of suicidal thoughts, and intentions was not adequately challenged.

	Risk assessment was also severely compromised because there was with no contact made with the family until 12.1.23, and no family involvement in key decisions made by the team. Mr Baylis was a voluntary patient during his final admission, and was allowed unescorted leave, on 10.1.23, which gave him the opportunity to take his own life. This should not have occurred. Had there been family involvement in the decisions regarding leave arrangements, had there been greater weight given to the repeated, and very recent, very serious suicide attempts, together with more direct involvement requested of the Specialist Depression service, it is unlikely that this incorrect decision would have been made. Accepting that it would have been difficult to deny him his unescorted leave request, (as this was his wish, and he was an informal patient), had he been told this was not agreed, it would have likely precipitated either a further Mental Health Act assessment, or more likely his agreement to comply, as had occurred in previous admissions. This would have allowed for a longer treatment period, hopefully (if it had been considered) family participation in his care and support plan, as previously, further involvement of the Specialist Depression service, with a more robust management plan, that acknowledged that depression was the most likely explanation for his presentation, and a managed discharge to a safer environment. The lack of family input during his final admission, to Mr Baylis's risk assessment and support and safety planning, together with the serious under estimation of the real and imminent risk of death from suicide, and the incorrect decision to allow unescorted leave, all probably made a more than minimal, negligible, or trivial contribution to his death. Trust Policies and procedures regarding family involvement in assessment of risk, care plans, and MDT meetings, were not followed. The Trust procedure entitled 'Care Planned Leave/Time off the ward for inpatient areas of the mental health services division', was not followed. There was no evidence of joint planning of leave arrangements, to include family, very limited evidence of consideration of identified risks, very limited consideration of any possible leave restrictions, and no contact with family to ask them if they had any concerns about leave arrangements. Additionally, and importantly, there was no clear evidence of an assessment of Mr Baylis's mental state, nor a robust assessment of risk, before each period of time off the ward. There is no evidence of completion of the sheet- 'Appendix 1 of the Planned Leave procedure : Time Spent off the ward' at any time. Had it been completed it would have captured a signature of the staff member allowing Mr Baylis to leave, details of his time leaving the ward, planned time of return, planned destination, actual time of return. This sheet was not a familiar document to the senior treating team on Kingsley ward. . Detailed findings as to how he came by his death are described within a written Determination dated 4.8.23, appended to this report
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 will 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. Family are not routinely or regularly involved in a patients risk assessment, care plan and safety planning. 2. Inadequate suicidal risk assessment and suicide mitigation

	3. Lack of compliance with the Trusts Planned Leave policy. 4. Inadequate review and incident investigation following a serious suicide attempt or a death I am not reassured that necessary actions to address these serious issues identified are in place.
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 the **29th 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. Mr Baylis's family 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.