	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive, Birmingham and Solihull Mental Health NHS Foundation Trust
1	**CORONER** I am Mr James Bennett, Area Coroner for Birmingham and Solihull.
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 2 January 2024 I commenced an investigation into the death of Kieran Lavin. The investigation concluded at the end of the inquest held between 22-25 July 2024.
4	**CIRCUMSTANCES OF THE DEATH** Kieran had experienced anxiety and depressive symptoms for around 10 years with worsening symptoms in late 2023. In November he consulted his GP having inadvertently stopped taking his anti-depressant medication. On 5/12 he reported worsening symptoms after restarting his medication for two weeks, and said he had thoughts of jumping in front of a vehicle and an overdose, citing the breakdown of his relationship with his wife as one of the triggers. He was referred to the Crisis team and assessed on 7/12 reporting no active suicidal plans. His anti-depressant medication was increased, and he agreed to be seen routinely in 4 months. The following day, on 8/12 he booked into a hotel to overdose on his medication with alcohol. He was surprised to wake up and was admitted to the Emergency Department early on 9/12. Psychiatry & Liaison referred him to the Psychiatric Decisions Unit ('PDU') for further assessment as he could not guarantee his safety. He arrived at the Oleaster Centre, Birmingham at 9:55pm. The following day, early morning on 10/12 during a nurse assessment he said he was angry the overdose attempt had not worked, and if he went home, he would maybe throw himself in front of a lorry. He cited in part the relationship breakdown with his wife as one of the triggers for his presentation. Later that day, he was assessed by a consultant psychiatrist whose impression was of a depressive episode, and that Kieran required informal admission as he did not feel safe to go home, which Kieran agreed with. The following day, by 11am on 11/12 Kieran proactively contacted a second nurse reporting when outside the unit for a cigarette he had terrible thoughts, and he does not feel safe going outside because he thinks he needs to kill himself and he will run and jump in front of a car or train. Around 1-2pm he was assessed by a junior Dr and reported no active suicidal plans, but her impression was he was very anxious and depressed, and the plan was maintained. The long wait for a bed was due to the mental health service having no available inpatient bed. A private mental health service agreed to admit him in Willenhall. Kieran's wife had arrived to drop off some clothes and Kieran asked if his wife could drive him. The bed manager, also the nurse in charge of the Oleaster Centre, had intended that Kieran be transported via taxi accompanied by a member of staff, but agreed to his wife driving him on the basis Kieran was a voluntary inpatient, wanted treatment, and assessed his presentation on and off the PDU as raising no safety concerns. He did not record his risk formulation. He was not aware of the two reports of suicidal ideation via road traffic collision. Had he looked at the 'level 1 risk screening' neither nurse had at this stage updated the 'suicide' box. No record of his suicidal ideation on 10/12 was ever added, and the suicidal ideation reported on the morning 11/12 was not added until 8:51pm and after the incident had occurred. Whether his wife's presence would exacerbate Kieran's presentation was not fully considered, or the length and nature of the journey. His wife was not informed of Kieran's reported suicidal ideation. The mental health service's policies, procedures and guidelines did not set out a clear approach to assist regarding what should happen when a patient requests for family to transfer them to another location for an informal admission. Kieran left with his wife in her car around 7:45pm. Shortly after 8pm, having just spoken on the phone to his mum, he suddenly proceeded to open the passenger door whilst in lane 1 of the M5 motorway. His wife attempted to physically stop him

whilst managing to move to the hard-shoulder whereby Kieran exited the passenger door and walked around the rear of the car into the path of an oncoming large lorry in lane 1, and thereafter was struck by a second car. He was confirmed deceased at the scene from the consequential injuries (1a. Multiple injures).

The inquest conclusion was: "Suicide, contributed to by a failure to conduct an adequate patient transport risk assessment which would have likely changed the outcome."

CORONER'S CONCERNS

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. Critical suicide risk information was not recorded at all or not recorded in a timely manner. On 10/12/23, the experienced nurse did not record at all in the 'suicide' box on the 'level 1 – risk screening' the first report of suicidal ideation via road traffic collision. She described this omission as an error and the likely explanation was that she was the only nurse working on a very busy shift. On 11/12/23, the experienced nurse did not in a timely manner record in the 'suicide' box on the 'level 1 – risk screening' the second report of suicidal ideation via road traffic collision received by 11am. She said the likely explanation for not updating the 'suicide' box until 8:51pm (and after the nurse-in-charge made his transport risk formulation) was that she was the only nurse working on a very busy shift. The experienced Nurse-in-Charge did not record at all his transport risk formulation saying that was not his usual practice. The Patient Safety Manager said long standing trust policy required clinicians to record key information as soon as possible. I am not persuaded this long standing policy is sufficient by itself to remove the risk in the future of critical suicide risk information not being recorded at all or in a timely manner given three experienced nurses within 24 hours failed to follow the policy.

2. Post-death trust learning led to new guidance for when an informal patient requests family, carer, or friend transport them from PDU. For ease of reference it states:

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> *"Where appropriate, it is reasonable for the option of an informal patient to be transported by family/carer/friends. In all such cases, decision needs to be based on the risk/benefit ratio and this also needs to be clearly discussed with the person transporting to make sure there is understanding and agreement. This needs to be clearly documented within the patient's notes. If there is any concern or disagreement expressed by the person, family/carer/friends, then alternative arrangements need to be made by us."*

I am not persuaded this is sufficient to remove the risk of an inadequate risk assessment in the future. By way of contrast, trust guidance C52 'Mental Health Act Transport of Patients' - which applies when a patient has been assessed under the Act and ambulance service transport is to be used - at paragraph 12 includes 15 specific questions that the risk assessor should ask as part of the transport risk formulation, including: *How far does the patient have to travel? What is the patients age and gender? What is their current state of mind*? *Is there a risk to the driver/accompanying individuals*? The updated guidance cited above is absent any equivalent specific questions or assistance on when it is or is not appropriate. For example, in Kieran's case clinicians were aware his sex, age, and background of relationship breakdown statistically recognised him as being at a higher risk of suicide, PDU is only intended for a brief stay whereas Kieran was there for nearly 48 hours and his state of mind was not assessed in the hours before the risk formulation (even thought it was known to fluctuate), the journey if considered would have been noted to take him away from local roads onto a high speed motorway, and his wife/the driver was known to be a trigger for his low mood. Further, there was no consideration of what his wife had to be told to ensure she was safe, providing genuine informed consent given the interplay of patient confidentially. In Kieran's case the transport risk formulation did not consider whether his risk of suicide included road

	traffic collision vs an unrelated mechanism. My concern is the above cited guidance in simply stating the decision should be based on 'appropriateness' and 'the risk/benefit ratio' does not sufficiently prompt clinicians to consider the full range of key issues and is inconsistent with the more expansive guidance in C52 for when an ambulance is to be used. For completeness, (1) there was discussion during the inquest about why there cannot be a blanket ban on informal patients with recent suicidal ideation via road traffic collision being transported by family etc given they represent a very small cohort of patients. If no such ban is considered appropriate, in my view, the need for more expansive and specific guidance for clinicians equivalent to C52 is increased, and (2) there was discussion at the inquest of a transport risk formulation based on a points system with a written draft suggestion from the Family's counsel; I attach a copy which may be of assistance for the trust when deciding what if any action to take.
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 26 September 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. Kieran's family. 2. Insurers: [redacted]. I have also sent it to [redacted], Chief Executive, NHS Birmingham and Solihull Integrated Care Board who may find it useful or of interest. 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	**1 August 2024**  **James Bennett** **HM Area Coroner for Birmingham and Solihull**