REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **[redacted], President of the Royal College of Psychiatrists** **21 Prescot Street London E1 8BB**
1	**CORONER** I am R Brittain, Assistant Coroner for Inner London North.
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	**INVESTIGATIONS and INQUESTS** Nicholas J'Dourou (date of birth 29 August 1977) died on 15 April 2024, whilst admitted as a voluntary patient at Highgate Acute Mental Health Centre ('Highgate'). He died from asphyxiation which arose from the placement of a ligature around his neck. His death was contributed to by a diagnosis of Bipolar Affective Disorder. I heard the inquest into his death on 24 January 2025 and reached the conclusion of suicide.
4	**CIRCUMSTANCES OF THE DEATH** Nicholas had long-standing mental health diagnoses and had been detained under the Mental Health Act on several previous occasions. His mood deteriorated at the beginning of 2024. He was admitted to Highgate in early April, after initial failed attempts to improve his mental health in the community setting, through altering his medication. On review by the ward consultant, his background diagnosis of Schizoaffective disorder was queried and a diagnosis of Bipolar Affective Disorder was favoured. He was under 'general observations', meaning that staff were supposed to be monitoring him on an hourly basis. Sadly, on the late morning of the 15 April, he was found in his room with a ligature around his neck. Signs indicated that he died several hours previously. After inspection of CCTV and records of supposed observations, it was apparent that staff had not monitored Nicholas as had been intended. However, it was not possible to conclude that this lack of monitoring contributed to his death.
5	**<u>CORONER'S CONCERNS</u>** During the course of this 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** following the inquest into Nicholas' death were as follows: 1. I heard evidence that cross-titration of medication, when changing from one regimen to another, is commonplace in psychiatric care but that how to undertake this process is determined predominantly by each individual prescriber's own practice, rather than any local or national guidance. The local psychiatric Trust provided evidence that they were in the process of developing local guidance. However, this was proving to be complicated, owing to the range of settings in which cross-titration may be carried-out (i.e. primary care, community psychiatry care, in-patient care), the complexity of the medications prescribed and a lack of evidence regarding how this should be undertaken. I am concerned that this commonplace and important process is seemingly undertaken on the basis of limited consensus and that the variation in care provided could result in future deaths. 2. I heard evidence that the local psychiatric Trust had undertaken a trial of electronic patient observation (i.e. automated monitoring of respiratory rate, temperature) but that this had been discontinued, owing to patient complaints regarding invasion of privacy. The issue of privacy and electronic monitoring on psychiatric wards is clearly a complex issue. However, in circumstances such as Nicholas' death, I am concerned that the lack of patient observation could result in future deaths. Regarding both of the above concerns, I heard evidence that the Royal College of Psychiatrists has not produced any formal guidance regarding cross-titration and use of electronic monitoring and that decision-making is ad hoc, based on individual/local practice.
6	**ACTION COULD BE TAKEN** In my opinion action could be taken to prevent future deaths and I believe that the addressee 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 8 April 2025. 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, Nicholas' family, the hospital Trust and the CQC. 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	11 February 2025  **Assistant Coroner R Brittain**