REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Oxleas NHS Foundation Trust** **2. Care Quality Commission** **3. NHS England** **4. Secretary of State for Health**
1	**CORONER** I am Andrew Harris, assistant coroner for the coroner area of South 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** On 15th January 2020 an inquest was opened into the death of Mr Paul Timothy Dunne, aged 45, on 02.01.20. On 10th April 2024 I was assigned to investigate this legacy case. The inquest engaged Article 2 ECHR and concluded on 19h December 2024. The medical cause of death was: *1a Asphyxia. 1b Suspension by neck* The conclusion as to his death was recorded as: *Mr Dunne committed suicide after absconding from urgent health care in an A&E department. Various failures in health care have contributed to his death:* *a) Failure of MH nurse at about 22.00 to make an adequate risk assessment and care plan, in particular not instructing 1:1 observations.* *b) Failure of a MH nurse in Home Treatment Team at 00.45 when he was intoxicated to make a meaningful risk management plan* *c) Failure of a MH nurse at around 03.00 to record and communicate at the time he finished his observations that Mr Dunne was high risk and required 1:1 observations* *d) Failure of an A&E triage nurse around 01.40 to escalate a deterioration in mental state when inserting the IV line* *e) Failure of the nurse in charge in the A&E department to ensure any observations after 03.30, when he was left on his own.* *Without these failures he would have been supervised, formally risk and capacity reassessed and either detained under the Mental Health Act and/or prevented from leaving and so would not have died when he did.*
4	**CIRCUMSTANCES OF THE DEATH** Mr Paul Dunne had a history of depression, anxiety, episodic alcohol abuse, suicidal ideation, suicidal attempts and two voluntary admissions to a mental health ward. He was brought to Princess Royal University Hospital A&E department at 20.40 on 1st January 2020, after an overdose of Paracetamol, having been persuaded by his family and emergency services personnel. He was at high risk of suicide and required continuous 1:1 observations, but never had them. There were poor communications between MH staff and A&E staff, exacerbated by separate medical recording. He deceitfully absconded four times whilst in the department, twice purchasing and drinking more alcohol. Security staff were not alerted to his risks. He did not have repeated risk or capacity assessments, nor have a Mental Health Act assessment, despite his circumstances and mental state deteriorating. After removing his IV line, he finally absconded for the final time, which could have been prevented. Police were notified, briefed by the A&E department just before 05.30 and took steps to find him, following their Missing Persons Policy. He was found dead, having suspended himself in the nearby children's playground, at 07.47 on 2nd January.

5	**CORONER'S CONCERNS** Many of the failings have been addressed locally. But during the course of the inquest the evidence 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 addressed to Oxleas and CQC** are as follows. – 1. Individual mental health professionals appeared to have gaps in knowledge and judgment. The director who was spokesperson for the Mental Health Trust did not appear to appreciate the seriousness of these deficits. • A mental health liaison nurse, who now is manager of these nurses, did not recognize the patient as high risk, despite his having been persuaded to attend A&E by the police against his will, having just expressed suicidal ideation, made a previous attempt, with alcohol intoxication and absconsion, as at the time he denied suicidality. Even in retrospect in court she did not acknowledge her misjudgement. She also asserted incorrectly that a patient who has mental capacity cannot be assessed under the Mental Health Act. • A mental health nurse of 9 years standing in the Home Treatment Team who acknowledged the risk to the patient's life could hardly be higher, failed to document his assessment, as he could not find anywhere to write it before going on his break. No staff acknowledged that he had informed them of the risk. He assumed the patient would get 1:1 monitoring, but did not direct anyone to the need. When asked what he would have done if he had known there were no staff to conduct 1:1 monitoring, he said that he could perhaps hang around for a bit longer. 2. The Mental Health Trust • Staff and it appears the director even at the time of the inquest did not appreciate that the A&E policies (Missing Persons, Shared Care) which required risk assessment after an absconsion and alerting managers to the need for extra temporary staff if 1:1 monitoring was needed, also applied to MH staff. • Evidence was heard that staff in KCH A&E and Oxleas NH Trust had been trained on different risk assessment documents. Although meetings had been reinstated between departments, there had been no audit of absconsions or MH liaison in A&E. The **MATTERS OF CONCERN addressed to NHSE and DH** are as follows. 3. MH staff and A&E staff write their clinical records in different systems and hospital staff do not have access to MH Rio records. MH staff attending A&E departments are asked to make a double entry in the A&E records as well. Here that was omitted, potentially with fatal risks. Moving to a combined electronic system (now identified as EPIC) has long been the aim of the local health providers, but evidence was heard that the pace of introduction, which is very slow, is in the hands of national NHS leadership.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation 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 May 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 and to the following Interested Persons (IPs): • [redacted], partner • Princess Royal University NHS Trust The Metropolitan Police who were also an IP, will receive a copy if they request it. My detailed findings and reserved judgement have been disclosed to all interested persons. I am also under a duty to send a copy of your response to the Chief Coroner I have also sent a copy to these organizations, who I believe may find it useful or of interest, and may also send them a copy of your response: • Royal College of Psychiatrists • Independent Advisory Panel on Deaths in Custody 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.
9	**13 March 2025** **Andrew Harris**