REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. South London and Maudsley NHS Foundation Trust**
1	**CORONER** I am Sian Reeves, 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 21 March 2023, an inquest was opened, and an investigation commenced, into the death of Christopher McDonald, who was aged 41 at the time of his death. The investigation concluded at the end of the inquest, which was heard over 7-days between 17 and 25 March 2025, with a jury. The inquest engaged the enhanced investigative obligation under Article 2 of the European Convention on Human Rights. The medical cause of death was: 1a Ligature strangulation; and 2 Schizoaffective disorder. The conclusion of the jury as to the death was that Mr McDonald died by strangulation by a ligature that he applied around his neck, but the evidence did not enable them to say what his intentions were. The following matters were recorded in the narrative conclusion: (1) There were shortcomings in the decision-making in relation to the suspension of Mr McDonald's section 17 leave on 24 February 2023, which possibly contributed to his death. The shortcomings were a lack of an individualised assessment and a failure to follow the "AWOL – Missing and Absent Persons Policy". Had a member of the National Psychosis Unit ("NPU") accompanied Mr McDonald back to the ward on 25 February 2025, it is possible that this may have mitigated any potential distress. (2) There was avoidable delay in the identification of the ligature by NPU staff. Had the NPU staff communicated Mr McDonald's medical history to London Ambulance Service staff, it is possible the ligature would have been discovered and removed in the first instance, possibly increasing his chances of successful resuscitation.
4	**CIRCUMSTANCES OF THE DEATH** Christopher McDonald was pronounced dead at 14:28 on 26 February 2023 at Bethlem Royal Hospital, National Psychosis Unit. Mr McDonald had a history of mental ill-health and had been formally detained under section 3 of the Mental Health Act 1983 since 14 November 2020. Mr McDonald was admitted to the Fitzmary 2 Ward of the NPU at Bethlem Royal Hospital on 7 July 2022. His diagnosis was schizoaffective disorder.

	After Mr McDonald went AWOL on 24 February 2023, there is no evidence of an assessment of whether it was appropriate to permit Mr McDonald to remain at his mother's address until Sunday 26 February 2023. In reference to section 10 of the Awol – Missing and Absent Persons Policy, v. 10, there is no evidence of an action plan being drawn up by SLAM staff and the police. No member of NPU staff accompanied the police to escort Mr McDonald back to the ward. When Mr McDonald returned to the ward on 25 February 2023, his level of observation should have remained intermittent, but there is no evidence of it being reviewed. There is no evidence of any observations between 12:15 and 9pm on 25 February. Mr McDonald was reviewed by the duty doctor at 16:50. There is no evidence of any discussion of observation levels. Section 17 leave was suspended pending review by the ward consultant. At 13:30 on 26 February 2023, Mr McDonald was found unresponsive. The NPU staff started an emergency response but did not find the ligature around Mr McDonald's neck. The LAS staff were not informed of Mr McDonald's history of suicidal ideation involving ligature. A senior LAS paramedic identified and removed the ligature between 1:50 and 1:55pm. Artificial ventilation was not applied by the ward staff because of the use of a non-rebreathe oxygen mask rather than a bag-valve mask. Due to the continued presence of the ligature it was not possible to administer successful CPR.
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 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: The evidence heard at the inquest demonstrated that staff working on the NPU did not have knowledge or a clear understanding of the "AWOL - Missing & Absent Persons Policy" of South London and Maudsley NHS Foundation Trust ("SLAM") Specifically: (1) Whilst there should be an individualised assessment of whether it is appropriate to suspend section 17 when a patient goes AWOL: (a) one member of staff at the inquest gave evidence that it was "standard practice" and "protocol" that leave would be suspended; and (b) there was no evidence of any individualised assessment in Mr McDonald's case. (2) The policy provides that SLAM staff should always accompany the police if the patient is to be returned from their home. This was not done in this case, and there was no evidence that any member of NPU staff considered this once Mr McDonald was located at his mother's address on 24 February 2023. (3) The policy provides that if the police are likely to be involved in returning the patient to hospital then an action plan – jointly drafted between the police and Trust staff - needs to be drawn up. This was not done in this case, and there was no evidence that this was considered or completed by SLAM staff.
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 2 June 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: • [redacted] I have also sent it to NHS England and the Metropolitan Police who may find it useful or of interest. 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 other 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.
9	**7 April 2025** **Sian Reeves**