Regulation 28: Prevention of Future Deaths report

Abdullahi Sharif ABOKAR (died 21.06.12)

	THIS REPORT IS BEING SENT TO: **1. Ms Wendy Wallace** **Chief Executive** **Camden & Islington NHS Foundation Trust** **4th Floor, East Wing** **St Pancras Hospital** **4 St Pancras Way** **London NW1 0PE**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 26 June 2012, my predecessor coroner, Shirley Anne Radcliffe, commenced an investigation into the death of Abdullahi Sharif Abokar, aged 22 years. I finished the investigation at the end of the inquest on 27 November 2013. The jury concluded that death was an accident, when Mr Abokar hanged himself at approximately 6.20pm on 16 June 2012 at Coral Ward of Highgate Mental Health Unit.
4	**CIRCUMSTANCES OF THE DEATH** Mr Abokar was a patient on a secure mental health ward, detained under section 3 of the Mental Health Act.

	He was found on a routine 15 minute check by a support worker, hanging by a bed sheet from smoke alarm wires pulled out from the ceiling. The support worker immediately took Mr Abokar's weight, raised the alarm and, assisted by another member of staff, got Mr Abokar down. Several members of staff responded to the alarm (captured on CCTV in the corridor) and assisted in giving cardiopulmonary resuscitation. Mr Abokar was taken to hospital, but survived only five days.
5	**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. Asking the suicide question** Several members of staff looking after him did not ask Mr Abokar if he had thoughts of taking his life. Some, including his ward manager, gave evidence that they thought that asking the question might give a patient the idea of taking his life, though evidence was given by the assistant director of nursing that this thinking is not accordance with training or accepted practice. One mental health nurse said that, although he would ask the suicide question of a patient who appeared isolated or in low mood, he could not ever remember asking that question, despite his work on a secure mental health ward. **2. Resuscitation** The psychiatry doctor who attended the resuscitation in progress (approximately seven minutes after Mr Abokar was discovered), found an ambubag mask on Mr Abokar's face, but no ambubag connected and no person holding the mask. The nurse who had been in charge of Mr Abokar's airway said that she had been giving him mouth to mouth resuscitation, though no other witness in the room saw this. No explanation was provided as to why she would have given mouth to mouth rather than use the ambubag present (even if the ambubag was not connected to a flow of oxygen).

	The nurse had left Mr Abokar in the middle of resuscitation, simply to go out into the corridor and ascertain the whereabouts of the paramedic. She said that she had left Mr Abokar's airway in the care of another member of staff, but she did not know who that person was, and all other members of staff in the room denied that his airway was ever left in their charge. She was out of the room for 50 seconds. The paramedic attending Mr Abokar after resuscitation had been ongoing for quite some minutes, said that Mr Abokar's head was not tilted back sufficiently, and the ambubag reservoir was not inflated because the oxygen cylinder, whilst connected, was not switched on. Neither of the paramedic's observations was accepted by the nurse with control of the airway, though he clearly has a great deal more experience of resuscitation than she. The nurse also said that a colleague, though she did not know who, had connected the ambubag to the first oxygen cylinder; and then a colleague, either the same colleague or a different one, she did not know, had connected the ambubag to a second cylinder; though all other members of staff in the room denied that they had done this. It appears that Mr Abokar's ventilatory support was significantly compromised by the way in which it was conducted. It was entirely unclear what impact, if any, this had on Mr Abokar's potential recovery, though that would not necessarily be the case for another patient in a similar position. **<u>Matters already addressed</u>** There were other issues regarding the resuscitation, and also the availability of ligature points, that have already been addressed by the trust and are already being shared with other hospitals at a national level.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you and your trust 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 28 January 2014. 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 following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • Professor Dame Sally Davies, Chief Medical Officer for England • [redacted], sister of Abdullahi Abokar • Dr [redacted] formerly of Highgate Hospital • Ms [redacted] staff nurse, Highgate Hospital • Dr [redacted], consultant anaesthetist, Whittington Hosp 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 03.12.13