[REDACTED]
Chief Operating Officer,
Cygnet Healthcare Ltd.,
Cygnet Hospital Stevenage,
Graveley Road,
STEVENAGE,
Herts. SG1 4YS

Your ref: [REDACTED]

Our ref: NC/B2047B-11

8 November 2013

Dear [REDACTED]

Re: Inquest into the Death of Peter Patrick Adrian Barnes
Regulation 28 Report to Prevent Future Deaths

1. **Coroner**
I am Neil Cameron, assistant coroner, for the coroner area of West Yorkshire (Western) Area.

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 25 October 2011 I commenced an investigation into the death of Peter Patrick Adrian Barnes, 31. The investigation concluded at the end of the inquest on 6 October 2013. The conclusion of the inquest was that the deceased died from asphyxia caused by hanging, that he died in the grounds of the Cygnet Hospital, Wyke whilst detained at that hospital under Section 3 of the Mental Health At 1983, that he took his own life whilst the balance of his mind was disturbed, and that his death was contributed to by neglect in that the deceased's Responsible Clinician had not been given information about serious incidents which were known to nursing staff at the hospital which led the Responsible Clinician to make an inappropriate decision to grant the deceased unescorted leave which gave him the opportunity to take his own life.

4. **Circumstances of the Death**
The circumstances of the death were summarised in a narrative verdict by the jury at the inquest, which is in turn further summarised at paragraph 3, above. The serious incidents which were not drawn to the attention of the Responsible Clinician occurred on 1 October 2011, when the deceased was overheard talking about committing suicide by using his shoelaces and later the same day when he was observed to have marks on his neck. Although these matters were recorded by the nursing staff who observed them in the deceased's continuous medical record, they were not drawn to the attention of the Responsible Clinician when he chaired Multi-Disciplinary Team ("Ward Round") meetings on 3 October 2011 and 12 October 2011, and at each of those meetings the Responsible Clinician made decisions to grant the deceased unescorted leave.

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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) The hospital's systems by which information about patients relating to matters which had been observed by nursing staff - including in particular information about serious incidents - were communicated to the patients' Responsible Clinician appeared to be inadequate to ensure that such information was full and/or accurate and/or up to date.

(2) The hospital's systems by which decisions about patients' care made by the Responsible Clinician were communicated to nursing staff appeared not to have operated properly and accordingly may be inadequate to ensure that such information about such decisions is communicated in an appropriate and/or timely manner.

(3) There appeared to be no system of checking upon or auditing the systems referred to at paragraphs (1) and (2) above to ensure that the Responsible Clinician was receiving full, accurate and up to date information and that nursing staff were receiving appropriate and timely information about the Responsible Clinician's decisions.

(4) There appeared to be no system to ensure that members of patients' families were invited to be involved in the process by which decisions are made about their care, notwithstanding that they may often be able to impart useful information based upon the patient's past behaviour, potentially including information about particular matters which might increase or decrease the risk of harm to or self-harm by such patients.

(5) The hospital's procedure for responding to patients being absent without leave included reporting such patients to the police as missing persons, but did not appear to be adequate to ensure that members of staff so reporting, or thereafter giving further information, to the police had access to all of the information about the patient which was likely to be required by the police for the purpose of their enquiries.

6. **Action Should be Taken**
In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation 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 3 January 2013. I, the coroner, may extend the period, and do hereby so extend it (in the light of the forthcoming Christmas vacation) to 18 January 2014.

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:

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8 November 2013

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. Date: 8 November 2013

Yours sincerely,

Signed on behalf of
N. A. Cameron
Assistant Coroner
By T. H. Ratcliffe, Assistant Coroner

Cc The Chief Coroner