H.M. Senior Coroner, South London Area

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Coroners & Justice Act 2009; Coroners (Investigation) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive of Central and North West London NHS Foundation Trust** Trust Headquarters, Stephenson House, 75 Hampstead Road, London NW1 2PL
1	**CORONER** I, Dr Roy Newberry Palmer, am senior coroner for the South London coroner 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, SI 2013 no. 1629
3	**INVESTIGATION and INQUEST** On 3rd July 2011 I opened an inquest into the death of Simon William McAndrew, aged 38 years. The inquest was concluded on 13th February 2014. The cause of his death was 1a hypoxic ischaemic encephalopathy 1b fatal pressure to the neck/suspension I recorded a narrative verdict on this matter, as follows: Simon McAndrew had a long history of emotionally unstable personality disorder, substance abuse and self harm. He was a voluntary inpatient of the Gordon Hospital for several months in 2010.On his discharge arrangements were made for him to be resident at Jordan Lodge in Croydon but his ongoing psychiatric care was supervised at the Gordon Hospital. He harmed himself in April 2011 and attended Croydon Hospital where he was assessed by the emergency department and by a psychiatric liaison nurse. His methadone prescriptions were managed at Lantern Hall, Croydon. On 28th June 2011 at Jordan Lodge he was seen holding some belts. Fearing for his safety staff at Jordan Lodge removed the belts and monitored him closely for some time. He appeared to settle down. They did not seek advice. At about 01.00h Simon McAndrew was found hanging from a tree in the garden at Jordan Lodge. Staff cut him down and initiated cardiopulmonary resuscitation. Police and ambulance personnel were called, assisted in resuscitation and transferred Simon to Croydon Hospital where he was taken to the intensive care department and neuroprotective strategies were implemented. His condition deteriorated on 30th June 2011 and he was found to have suffered an extensive subarachnoid haemorrhage. Brain stem testing was performed on 3rd July 2011. Death was confirmed at 11.45h. He died as a consequence of an act of self harm. Issues of poor communication and confusion about who was responsible for his

	psychiatric care were probably not contributory to his death but do warrant a Prevention of Future Deaths Report
4	**CIRCUMSTANCES OF THE DEATH** See box 3 above; Simon McAndrew died on 3 July 2011 at Croydon University Hospital, London Road, Croydon, Surrey. He was a voluntary residential patient at Jordon Lodge, Croydon, at the time of his death. He had suffered brain damage as a child and childhood epilepsy. Into adulthood, he experienced drug abuse issues and was diagnosed with Emotional Personality Disorder, a chronic mental health condition. On 30th June 2011 Mr McAndrew was seen by staff of the home where he resided to be making nooses from belts. They were confiscated, and he was placed on a one-to-one watch. This was relaxed later in the evening when he appeared to have clamed down. He later used a plastic washing line to hang himself from a tree in the garden of the home, having told staff he was going outside for a cigarette. He was discovered and two staff members attended the scene, performing emergency First Aid. An ambulance was called and Mr McAndrews was taken to hospital, where he died on 3rd July 2011.
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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you. Representatives of your Trust attended the Inquest and many brief you more fully. In summary the **MATTERS OF CONCERN** are as follows. There are issues of poor communication which need to be addressed. I acknowledge that even the most detailed communication in this instance may not have averted Mr McAndrews' actions and subsequent death. However, circumstances in which important information is not being shared effectively may result in avoidable tragedies in future if remedial action is not taken. I invite the Trust to consider whether improvements can be made, particularly with regards the sharing of information between different NHS Trusts. In the comments that follow I do not intend to be prescriptive or to make firm recommendations; rather I seek to encourage you to consider the issues that arose and what might be done to try to prevent any recurrence. Mr McAndrew had a drug misuse issue and a mental health issue. Each was dealt with by different specialist psychiatrists. After a long period of in-patient treatment at the Gordon Hospital Mr McAndrew was located in a residential home in another Borough. His key caseworker was not easily able to keep in touch with him. His methadone management was managed by Lantern House, a local NHS facility in the London Borough of Croydon. When acute psychiatric issues arose Lantern House staff ordinarily worked in close liaison with the local acute mental health trust (SLAM). At the material time it was not appreciated that Mr McAndrew's psychiatric care remained with the Gordon Hospital. Correspondence from one trust to another was copied to the consultant psychiatrist at Lantern Hall but was not seen by her. This might have been because she was on leave when it was received and the copy letter was then scanned into the electronic patient record but not left in the consultant's 'in-tray' for perusal on her return. An opportunity was missed to ensure effective communication with the Gordon Hospital staff. Junior staff, whether medical or nursing, had no 'front page' on the electronic patient record that contained information that the primary psychiatric care was held by the Gordon Hospital; so an inappropriate referral was made to SLAM.

	For so long as the national computer database for all NHS patients is a far-off ideal, some better method must surely be devised to ensure that key clinical staff can access important information held electronically in a different NHS Trust. This is especially important in psychiatric illness, where patients may not be able to provide the relevant, important information themselves. One possibility raised during the inquest hearing - which might go some way in addressing this issue - is for patients to carry a "Crisis Card", containing details of the Consultant and Hospital responsible for the main psychiatric care. Whilst it is conceded that such cards cannot be compulsory, nor will they always be carried, the provision of such cards for voluntary uptake might be worthy of consideration. Those called upon to deal with crises in management would then more easily be able to ascertain important information to help with management. The Trust may also like to consider the unintended consequences of the use of different computer databases in Trusts and how they might better be managed. Even within individual computer systems, the evidence heard in this case suggests that the information may be available but often staff - particularly junior staff - do not know to look for it, may not know where to look for it and might not have the time to delve deep into the electronic record to find it. If a "front of file" note could be created in each case to record basic, essential information this may assist medical staff in discerning the appropriate mental health professional with overall care in any particular case. Of course, such information must be accurate and up-to-date. I believe it was accepted by all who so helpfully attended to give evidence at the inquest that there were too many miscommunications in this case and that steps should be taken to try to ensure an improvement. An additional point is that where discharged in-patients are resident in homes far distant from the 'base hospital' and their key caseworkers, a better means must be devised of keeping in touch with the patient. In this case the key caseworker conceded that she did not keep in touch with Simon as much as would have been the case had he remained resident locally. At best regular contact would have been by telephone rather than face-to-face, albeit that occasional face-to-face contact was being arranged. Please will you also consider whether a formal, written care plan should be provided to the distant residential home with clear guidance as to what is to happen in defined circumstances of crisis. If the staff at Jordan Lodge had had the benefit of a care plan, they might have contacted the acute psychiatric team on 30th June 2011 to seek advice as how best to manage the immediate crisis. In the absence of a care plan, and with residential home staff who are not mental health professionals, the staff who were on duty on the day were left to deal with the crisis as best they could. Is that state of affairs capable of improvement?
6	**ACTION SHOULD BE TAKEN** Although the death was to some extent impulsive and unpredictable, in my opinion a number of issues of concern arose in the course of the evidence that lead me to consider that action should be taken to prevent future deaths. I believe you have the power to facilitate appropriate action being taken with a view to improving communication between institutions and individuals and to arrange for staff who are called upon to deal with crises have immediately available to them in easily accessible form a summary of the main physical and mental health issues and details of the teams that are responsible for relevant aspects of patients' care.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by April 19th 2014. I, the coroner, may extend the period upon request. Your response should contain details of action taken or proposed to be taken, setting out the timetable for action, or should 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 persons • Chief Executive of South London and Maudlsey NHS Foundation Trust Addictions Clinical Academic Group (CAG) Lantern Hall, 190 Church Road, Croydon, CR0 1SE • [redacted] General Practitioner; Violet Lane Medical Practice, 231 Violet Lane, Croydon, CR0 4HN • The Manager, Jordan Lodge Residential Home 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	**Dr R N Palmer** **Senior Coroner, South London Area** **19th February 2014**