: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Greater Manchester West Mental Health NHS Foundation Trust 2. Department of Health 3. Chief Coroner 4. Family of the deceased, - [redacted] 5. [redacted] DAC Beachcroft 6. [redacted] Broudie Jackson Canter
1	**CORONER** I am the Senior Coroner for the coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and regulations 28 and 29 of theCoroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 8th August 2013 I commenced an investigation into the death of Mark Darren Bartholomew, then aged 41 years who on the 19th October 2012 was admitted to the Grasmere Ward on the Edenfield Unit at Prestwich Hospital having been transferred from HM Prison Strangeways. The Investigation was concluded on the 15th May 2014 following an Inquest with a Jury. The medical cause of death was that of 1a) Hanging. The conclusion of the Jury was that the deceased did a deliberate act causing his death but the evidence does not fully disclose whether or not he intended or was capable of forming an intention that the outcome be fatal.
4	**CIRCUMSTANCES OF DEATH** Briefly and by way of background, the deceased had a longstanding diagnosis of paranoid schizophrenia. On the 28th June 2012 he was arrested for a serious offence and remanded eventually to HM Prison Strangeways. Whilst on remand, he made an extremely serious attempt to self-harm and following his transfer to the Grasmere Ward, presented as extremely deluded and suicidal. As time progressed, the evidence adduced demonstrated an improvement in his mental state although in January 2013 he asserted that he would not disclose his suicidal feelings or intentions to staff in the future. At approximately 00:25hrs on 25th July 2013during a routine observation check, he was seen with the rear of his head adjacent to the observation window within the door. Considerable force was used to open the door and it subsequently became clear that the ligature around his neck had originally been secured within the frame and the closed door.
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. Notwithstanding the Trust's policy entitled '2999 Procedure' the purpose of which is to advise staff of process during a psychiatric emergency, it was clear that the response to external emergency services was inadequate. More particularly:- • The informant was unable to provide the emergency controller with either the name or age of the patient; whether he was still breathing; and whether a defibrillator was available. • Essential documentation (the observation record for the relevant 24 hour period) was mislaid and not available for the Inquest.

	• Originally, a joint visit by both Police and Trust staff was arranged for the purpose of relaying news of the deceased's death to the family. By reason of a lack of communication, the family were notified following an attendance by uniformed officers whereupon the deceased's Mother telephoned the Trust. 2. Ligature Cutters – The Consultant Forensic Pathologist, [redacted] confirmed in evidence that time was very much of the essence. Specifically he stated 'following application, pressure through the ligature, and unconsciousness may ensue within a few seconds with death within minutes' The registered nurse in charge of the ward ran to the scene, but then had to retrieve the ligature cutters which should have been in the front pocket of a bag attached to a hook on the wall in the secure clinic. The ligature cutter had in fact been used following an incident a week earlier and had not been returned. Despite a regime of daily checking, the absence had gone unnoticed. The Nurse-in-Charge immediately retrieved the ward scissors from a locked drawer and the ligature was subsequently released albeit approximately 2 minutes later. To the credit of the Trust, the practice of daily checks for equipment has now been superseded by a check at the commencement of each shift. Although alerted to Department of Health guidance from 2007, I can find no detailed guidance with regard to either access to or the type of ligature cutter to be used. Evidence was given to the Inquest by the Senior Investigating Officer of Greater Manchester Police who made reference to the use of an implement carried in a pouch by Custody Sergeants within the Custody Office of designated Police Stations. The Senior Investigating Officer was not aware of any untoward incident arising from the use of such an implement which according to the Officer cannot be used to inflict harm on a third person. If the Security Nurse who had initially attended had been carrying such an implement, the ligature would have been released within a matter of seconds rather than minutes. 3. The Trust has a documented Observation Policy. Whilst the Policy requires records to be *contemporaneously* recorded, it does not specify how this is to be achieved. The actual observation sheet apparently in use at present indicates a poor level of detail as to who and when it is completed and in its present format would not withstand a rigorous audit.
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. Such action would include a review as to the adequacy of the policies and procedures at present in place; a review of training of relevant personnel; the possible use of laminated checklists and pro-formas that may be used in the event of an emergency.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 16th July 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 Chief Coroner and to the following Interested Persons namely Greater Manchester West Mental Health NHS Foundation Trust, Department of Health and [redacted] 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 from. 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: 21st May, 2014 Signed: