	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Lisa Rodrigues, Chief Executive, Sussex Partnership NHS Trust, Swandean, Arundel Road, Worthing, West Sussex BN13 3EP**
1	**CORONER** I am Christopher Wilkinson, assistant coroner, for the coroner area of West Sussex
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 the 6th June 2012 the senior coroner for West Sussex commenced an investigation into the death of JOHN LEON NAYLOR WALKER born 12 September 1940, being age 71 at the date of his death. The investigation concluded at the end of the inquest on 21 May 2012 following two days of evidence (on 3 May and 21 May 2012). The conclusion of the inquest was that Mr Walker had died as a result of hanging and that he had taken his own life whilst suffering from depression and anxiety.
4	**CIRCUMSTANCES OF THE DEATH** 1. Mr Walker had a history of mental health issues which developed in 2006 when he suffered a sudden breakdown, attempting two overdoses of prescription medicine. He was gradually helped back to full mental health by 2009 and lived a reported full and illness free life until March 2012. 2. On 19 March 2012, an altercation with a neighbour triggered a further breakdown, as a result of which, via referral to Mental health services, he was hospitalised as a voluntary patient at Langley Green hospital, West Sussex on 10 April 2012 with symptoms of depression and suicidal ideation. Langley Green is not a Psychiatric Intensive care unit (i.e. it is not secure), but it does control visitors to the wards and monitors its patients. 3. Mr Walker stabilised on the ward, which he had described as a safe environment where he felt he could be protected from his impulsivity to self-harm in times of low mood. 4. Despite repeated denials about on-going suicidal ideation, and an apparent improvement in his condition, Mr Walker made a further serious and impulsive attempt on his life on 19 April whilst on a visit home. 5. Mr Walker was subsequently released from the hospital's care on 1 May 2012, under supervision of the Crisis Resolution Team. He continued to express suicidal thoughts to his family and on 14 May made a further opportunistic attempt on his life when his wife was distracted for a period of 10mins on the phone. 6. Following an assessment at a local hospital (St Richard's) on 14 May, Mr Walker was re-admitted, as a voluntary patient, to Langley Green on 17 May 2012. He was assessed on admission by a second year core trainee in Psychiatry, who whilst having sight of his transfer notes, could not recall reviewing the 'e-notes' on the system (which would have been her normal practice) and did not have available to her notes from Mr Walker's 1st admission to the hospital as they were at another location for Mr Walker's discharge summary. A full assessment was undertaken with Mr Walker in person, but the Dr did not get an opportunity to meet or discuss matters with his wife.

7. The assessment considered the prior attempts on his life and the apparent speed and impulsivity with which they had been undertaken. His playing down of their severity in interview was taken as an indication that his risk was unlikely to have changed quickly and he was admitted on eyesight observations on account of the perceived high risk that he posed to himself.
8. In evidence, the Dr felt sure that she would have conveyed the issues over his impulsivity and speed of action to nursing staff, and whilst it was noted in her notes that his risk was 'very difficult to assess' it was clear that the wider picture of these factors had not been fully ascertained. In evidence, [redacted] had described how she had explained on a number of occasions to the hospital the fact that Mr Walker was impulsive but that he had good insight into his condition and understood and feared his impulsivity. Mr Walker, it was said by his wife, described himself frequently as 'needing to be protected' and 'to be kept safe until his medication worked' The Dr was not aware of comments and specific concerns which had been raised by the family and it appears therefore that these were not effectively conveyed. It was believed by the Dr however that the nursing staff would have been aware of these matters from previous contact.
9. On 18 May, observations were reduced to 10 minutes.
10. On 19 May a risk care plan for Mr Walker was prepared. This was undertaken by a temporary charge nurse without, it appeared, wider input from the MDT. The nurse, the evidence established, had not been present at admission. The risk care plan was based on admission notes, but was not informed by any wider discussions with the MDT or family. It was not recalled as to whether it was subsequently discussed with staff. The risk plan was described as only being meant to be a 'stop gap' as a guide for the team, in the belief that a future risk assessment would be undertaken. It proved however to be only a factual recount of the events leading up to Mr Walker's admission, failed to expand or consider any of the comments raised in the admission assessment and made no mention of impulsivity, known triggers, protective factors, or of the speed with which Mr Walker could act, which was of particular concern to the family. No further risk assessment was undertaken or risk care plan prepared, although the inquest was not able to establish why.
11. On 19 May observations were reduced to 15 minutes and on 24 May, were further reduced to 30 minutes. There was no clear indication in the notes as to the reasoning for this, decisions it was established being based on MDT discussions, recording only the changes in observations and not the rationale. Observations remained at 30 minutes until 1 June 2012.
12. On 1 June, at some point just after 10.30am, following the 30 minute observation, Mr Walker, with the assistance of a stool from the common room, scaled a 2m fence surrounding the ward's courtyard, entered the outer gardens of the hospital, scaled a further exterior fence and travelled a distance of approximately 0.25 miles on foot before coming across a secluded area of wood by grazing fields.
13. The evidence showed that Mr Walker found a length of fencing tape at the location which he used to suspend himself from a tree at some time between 11 to 11.15am. Mr Walker was not discovered missing from the hospital until the next observations round for him at 11am. The Police were called (following the instigation of the hospital's AWOL policy and a thorough search of the hospital) at 11.50am. Police confirmed that Mr Walker was discovered by passers-by at approximately 11.15am that morning.

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 consideration of, contribution to and preparation involved in risk care planning for Mr Walker was insufficient in its scope and depth in order to provide any informed basis on which an active and proper assessment of his continuing risk (factors) could be made. Properly detailed, and the issues communicated amongst all members of the MDT, this may have better informed thinking with regard to the observation levels set. It is of concern that this risk care plan was neither revisited nor revised.
(2) There was no clear rationale provided for changes in observation levels in the notes or any explanation given in writing as to the considerations or risk factors taken into account. Whilst accepted that these matters may have been discussed, written evidence would have provided clarity and a point of reference for further assessment in light of any change in presentation or condition. The fact that observation levels only decreased (despite evidence heard at the inquest that Mr Walker was expressing ever darker and suicidal thoughts in the week before his death),

	without explanation, remains of concern. (3) Whilst it was accepted in evidence that the hospital's AWOL policy was robust and activated and implemented appropriately, concern was raised by the family with regard to the length of time taken before Mr Walker could be declared missing and the police informed. (4) At the time of the incident the fences surrounding the external common areas of the ward were of a scalable height by any patient determined enough to do so. It is accepted that this has been subsequently addressed.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and Langley Green Hospital 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 7 November 2013. 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: 1. [redacted] wife of the deceased; and 2. [redacted] Legal Support Manager, Sussex Partnership NHS Foundation Trust 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: 21/08/13** **SIGNED: Christopher Wilkinson, Assistant Coroner, West Sussex**