REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Constable, Greater Manchester Police 2. [redacted] and the Practice Director, Green Surgery, Manchester 3. MEDACS Healthcare
1	**CORONER** I am Mrs L J Hashmi, Assistant Coroner, for the coroner area of Greater 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 the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 29th September 2014 I commenced an investigation into the death of **Lucasz Lewandowski.** The conclusion at inquest was Misadventure. The medical cause of death was 1a) Severe Traumatic Head Injuries. Toxicological analysis showed the presence of cannabinoids and emergency medical treatment drugs.
4	**CIRCUMSTANCES OF DEATH** The deceased had moved to the UK some 5 years prior to his death. He was a hard-working, intelligent man who, up until late 2012, had been both physically and mentally fit and well. In around February 2013, the deceased's family and a close friend (with whom the deceased lived and worked) noticed a marked change in his mental health. He was exhibiting bizarre and erratic behaviour. The deceased was taken to see a private Psychiatrist who diagnosed Mr Lewandowski as suffering from acute paranoid psychosis. The Dr did not consider that the deceased was suffering from Schizophrenia and he explained his reasoning for this during the course of his evidence. The deceased was commenced on oral Olanzapine and was given a 2-week follow up appointment. The deceased failed to keep this and no further follow-up was organised. The Psychiatrist did not write to the GP/local NHS Mental Health team etc. following the consultation, nor did he see any reason to do so. It was the Psychiatrist's evidence that the Practice Director had taken the decision not to correspond with patients' GPs directly and that the CQC were aware of this practice. The deceased was reluctant to take medication and was for all intent and purpose non-compliant. He did not believe that he was unwell. For a period, the deceased's friend was able to covertly administer Olanzapine and there was a clear correlation between being medicated and an improvement in the deceased's mental health. Unfortunately, due to a change in shift patterns the deceased's friend was unable to sustain this course of action and Mr Lewandowski's mental health began to deteriorate again, due to ongoing non-compliance with his medication. The deceased's friend and sister both contacted the Psychiatrist (separately) to express their concerns about this and on each occasion were advised to take the deceased to the emergency room or his GP in the event of an acute exacerbation. The Dr did however alter

the prescription (March 2013) from tablet form Olanzapine to dispersible, as he thought that the deceased's reluctance might have been due to the fact he found it difficult to take tablets.

Between March 2013 and early July 2013, there appears to have been a period of status quo. However by mid-July changes were afoot in terms of the deceased's mental health again. Consequently, several attempts were made to by the deceased's friend to get help for Mr Lewandowski, predominantly via the emergency services.

There was evidence of police contact shortly before the deceased's death (14th – 15th July – the deceased had been lawfully arrest and detained in custody on suspicion of criminal offences), during which concerns were raised by the Custody Sergeant regarding the deceased's mental health and wellbeing. As the custody time limit was due to expire, the deceased was granted technical bail but detained under S.136 of the Mental Health Act, pending the arrival of the Force Medical Examiner (FME - employed by MEDACS). This was accepted by the Force as, *prima facie,* unlawful as the deceased had not been 'in a public place'. However it took a pragmatic view - that it was less stressful for the individual to remain detained than to be released and re-detained as soon as he stepped into a public area. This was based on understandable concern for the deceased's safety and welfare.

Significant delay ensued in securing the attendance of the FME (no less than 7 hours after having been initially called to attend). This was put down to the pressure of work on that particular day however during the course of the evidence GMP acknowledged that the demands placed upon MEDACS by the Force had increased considerably and certainly above the scope initially envisaged under the terms of their contract.

The deceased was however eventually assessed by the FME and deemed fit to be detained, interviewed, charged and released.

On the morning of the 16th July, Mr Lewandowski attended his place of work and spoke to his manager. The manager formed the view that the deceased's behaviour was odd and called an ambulance. He notified the deceased's friend of Mr Lewandowski's whereabouts as he was aware that fact that he had reported him as 'missing' the day before. Paramedics assessed the deceased and formed the view that he had mental capacity. He was encouraged to attend hospital of his own volition; he declined.

The Deceased returned to his flat and awoke his friend. Again, he was behaving strangely. The ambulance service was asked again to attend upon the deceased at his home address by his friend. They found accessing the property difficult and were made aware of the presence of a 'marker', suggesting a risk of violence. It subsequently transpired that the 'marker' in question related to the block of flats rather than an individual or particular property within the complex. Paramedics called for police attendance.

Due to the demands being placed upon the police service at the material time, their request was deferred for no less than 8 hours. During this period, the ambulance service 'stood down' until such time as the police could allocate a patrol. The deceased's friend continued to try and get help for Mr Lewandowski by contacting the emergency services. He was not kept updated.

Subsequent analysis of the sequence of events in relation to calls made to GMP Communications relating to this matter demonstrated ongoing series of errors including:

- Incorrect recording of the deceased's name
- Not reverting to clarify the name once an Interpreter was available to assist (the Deceased's first language was Polish)
- Staff did not follow escalation and call grading protocols where there were clear and unequivocal triggers to do so
- Unjustified decision-making and gaps in record keeping
- Evidence of less than best practice.

On the evening of the 16th July, after the close of business, Mr Lewindowski made his way onto the roof of his employer's building, disrobed to his underwear, ran to the end of the roof and 'dived' off. He suffered catastrophic head injuries, resulting in his death two days later.

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 timeliness of GMP's response, against a backdrop of lack of adherence to/use of the escalation and call grading protocols. 2. Lack of communication between GMP and MEDACS regarding the existence of their escalation protocol resulting in the delayed attendance of an FME. 3. The use of S.136 of the Mental Health Act due to lack of resources – albeit on logical, pragmatic grounds. 4. The psychiatric practice's failure and reluctance to correspond with a patient's GPs and/or other healthcare professionals following consultation, jeopardising continuity of care. 5. Clinical decision-making by a non-medically qualified Practice Manager. 6. The view of the physician - that responsibility for maintaining a patient's safety and wellbeing within the community rests entirely with the family and/or patient rather than the clinician.
6	**ACTION SHOULD BE TAKEN**
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by the 10th December 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: The Deceased's family Care Quality Commission North West Ambulance Service General Medical Council [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: 15th October 2014 Signed: