REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO** The Chief Executive Cheshire and Wirral Partnership NHS Foundation Trust Springview Hospital, Clatterbridge Health Park, Clatterbridge Road, Bebington.CH63 4JY
1	**CORONER** I am Andre Rebello, Senior Coroner, for the area of Wirral
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 19th July 2013 I commenced an investigation into the death of **Michael Gerard MCCRORY**, Aged **50**. The investigation concluded at the end of the inquest on 30th January 2015. The conclusion of the inquest was Ia Multiple Fractures, Injuries & Burns Michael Gerard McCrory intentionally ended his own life and the cause of death was aggravated by neglect.
4	**CIRCUMSTANCES OF THE DEATH** At approximately 10.40 on the 16th July 2013 Michael Gerard McCrory died in a collision between his motor car, a Ford Ka and a tree on Lever Causeway in Bebington, Wirral. No other vehicle was involved in the collision and Michael McCrory was the sole occupant of his vehicle. It is found so as to be sure that he intended his death by his actions. The fact that this could occur ought to have been known by those caring for him, at the time, as a real and immediate risk to the Michael McCrory's life and there were failings to take steps which might have been expected to avoid that risk. Michael McCrory had suffered from a mental illness diagnosed as a Bipolar Affective Disorder since 1998, in spite of which he was a respected, high achieving professional teacher who had been stable with treatment in the community. Michael McCrory was honest, eloquent and clear in his communications with mental health professionals. He self-reported to an emergency department and was admitted to in-patient treatment on the 12th January 2013 by the crisis team as a result of the manifestation of

unmanageable suicidal thoughts. After 12 days he was discharged to outpatient care. He had a brief second admission from 8th to 13th February 2013 and again continued with out-patient care. His third admission was from the 2nd to the 31st May 2013. Finally on the 8th July 2013 he was admitted having presented himself at the outpatient service with an overwhelming urge to end his life. He was admitted to manage risk of suicide as a voluntary patient initially on level 2 that is15 minute observations with only escorted absences from the unit, however the following day he was placed on level 1 - hourly observations whereby he could leave the unit with permission, the staff knowing his whereabouts when off the unit.

On the 13th July 2013 Michael McCrory reported to his wife, when she was visiting the unit that unbeknown to the mental health team he had left the unit taken a train from Spital Station to Eastham Rake and had considered throwing himself under a train. One reason for not doing so was out of consideration for the train driver. His wife reported this incident and these ideations to a nurse – however the fact that he had visited a train station was not understood by the mental health team - Michael McCrory was placed back on level 2 -15 minute observations the same day.

On the 15th July 2013 there was an emergency multi-disciplinary meeting for which Michael McCrory had prepared a clear but concise note of his explanation of his symptoms. He significantly stated, amongst other matters, "I do not want to kill myself, but suicide is a very attractive option when feeling this awful. Therefore I would like to stay ward based until such time as I start to feel better (I know I would be kept ward based anyway) – The professionals in the meeting did not read his communication and made a decision to reduce his observations to level 1. The reasoning for this change in observations is difficult to understand from the evidence but appears to be due to some concerns that Michael McCrory had been bored over the weekend and that the restrictions from the level 2 observations had a counter therapeutic effect giving him time to ruminate on negative thoughts. Michael McCrory's wishes were overridden. On the 16th July 2013 Michael McCrory had left the ward with permission and had drawn cash from a machine by 09.15. He had gone home taken his car and by 10.40 he had died from the effects of the collision.

Given the eloquent, honest and clear communications he had with healthcare professionals though there was always a risk of a completed suicide, the long term risk of suicide could have been managed with specialist services and his support network with him receiving inpatient care as he requested when required. His death was facilitated and enabled in part by the fact that the poor state of his mental health on the 15th July 2013 had not been fully appreciated, his care, treatment and supervision was not adequate and he was not listened to; in particular from the general trust of the evidence the following were all more than minimally or trivially contributory factors to a lesser or greater degree Michael McCrory's death:

a. Inadequate Discharge Planning and failures to refer to OT in February and June, resulting in a lost opportunity to provide an OT programme, (including documentation failing to identify a care coordinator following the 13.2.13 discharge].

b. Failure to record Michael McCrory's mobile phone number in the medical records.

c. Failure to complete the Doctor's health assessment documentation and failure of the consultant to identify that this had not been done

d. Inadequate Medication review by reason of the failure to consider if Lithium was at a therapeutic level and therefore to consider in line with NICE guidance

e. Failure to consider bloods at any point during the medication review

f. Failure to provide PRN medication diazepam / lorazepam –in response to Mr. McCrory's request

g. Failure to record the rationale for medication decisions and risks/ benefits

h. Care plan recording that the 72 hour intervention plan was "met" when it had not been done save for one recording within a 12 hour period

i. Delay in completing the care plan [12.7.13]

j. Allocation of Michael McCrory as a complex patient to a "designated nurse" who was a new member of staff who had not been trained or received an induction. Inability of Ward Manager to identify what was mandatory training was

k. Failures to update the care plan including failure of the consultant to consider the Care plan and key information and Failure of the Ward Manager to "audit" the Care plan and identify that 72 hour intervention plan was not completed

l. Inadequate recording [System and individual], no evidence of objective assessment of mood, depression, no documented risk assessment process in the notes in respect of risk of suicide

m. Inadequate engagement with Michael McCrory to assess and consider his mood "proactively" – no staff asked at any point to consider his writings seen by him to be making to inform thoughts and feelings and risks

n. Use of a system for making entries which was not covered by a policy and which encouraged a culture of limited entries in Care Notes which did not give a clear picture as to presentation.

o. Insufficient time for staff to engage with patients to assess mood, feelings

p. Failure to identify Michael had been off the ward on 12/7/13 – this failure is linked to inadequate /no systems – this failure is significant and gross and impacted significantly on the further failures and the failure to keep Michael McCrory safe

q. Inadequate system of recording for Level One observations and the fact that the system operated was in breach of trust policy which was within the knowledge of senior nurses/managers – there being no system to record the location or whereabouts of a patient given permission to leave the ward or the time they left – and further the policy operated breached the Trust leave policy in that it permitted patients to leave the hospital. Complete lack of understanding of the Therapeutic Observation Policy in respect of level 1 - when Michael McCrory left the ward on the 16/7/13 he merely asked for his cigarettes with no enquiry as to his whereabouts thereafter

r. Failure to record key information shared on 13/7/13 that Michael McCrory had been off the ward and to the train station with a plan to throw himself under a train – the full extent of the seriousness of this incident was not handed over to staff and appreciated in respect of the significant risk and had a significant impact. This was simply recorded as thoughts to throw himself under a train that had not been shared with staff – this in itself was significant information but the fuller information was essential to have been recorded, acted upon and investigated and it was not. Failure to accurately update the care plan and risk assessment on 13/7/13and to carry out a ward based investigation by the ward manager and DATIX incident report and Trust

investigation as at 13.7.13

s. The mental health team being depleted at the time of ECT clinics – both 12/7/13 and 15/7/13 when Michael left the ward were ECT clinic days

t. On the 15/7/13 when there was an emergency multidisciplinary meeting there was a failure to invite/contact [redacted] and to obtain her views in respect of downgrading observations

u. Failure to inform [redacted] that Michael was no longer ward based

v. Complete disregard for the patient's views expressed on the 15/7/13 in the morning at the meeting, in the letter and at the time of the decision to downgrade, in particular by failing to read the letter brought to the meeting

w. The decision to down grade the observation was a gross failing – this caused and contributed to the death directly letting Michael off the ward when he had communicated what he would do if not ward based

x. Failure to identify at the meeting that the care plan and risk assessment had not been updated with no documented risk assessment having taken place on 15/7/13 with no rationale recorded for the decision to downgrade to level 1 in the notes

y. Failure to tell the patient that consideration had been given at that time by the consultant to a referral to the specialist service in Manchester in response to his documented comment "I will try anything". This comment is also at odds with the comment that ECT did not work last time and it being documented that "would be futile" which would more likely have depressed Michael McCrory's mood. The onus was inappropriately placed on Michael to approach staff - "Take self-responsibility" * Not revisiting the decision to downgrade to level 1 when making the entry at the end of the shift and having seen the further entries made including "immense sadness".

z. The delay in responding to Michael McCrory being missing after 9.30 on 16/7/13, by not contacting [redacted] earlier given the unit had failed to record Michael McCrory's mobile phone number.

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. –

a. I report the above findings for your attention and comment with regard to action taken to prevent future deaths.

b. In addition clear evidence was heard that though the therapeutic observation policy had been amended the amended policy still required the whereabouts of a patient on level 1 observations to be known but the practice was still to just record that the person was O (off the ward) as opposed to (Out with permission from a specific time going to a specific location).

	c. The inquest was heard in January 2015 and it was unclear from the evidence as to what training, support and professional development had been given to the staff involved and staff generally with regard to minimising the risk of recurrence of this type of tragic eventuality.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 27th March 2015. 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 The Family of Mr. McCrory The Care Quality Commission 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	[redacted] **André Rebello** **Senior Coroner for the** **Wirral Coroner Area** **Dated:** 30th January 2015.