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:** 1. **Avon and Wiltshire Mental Health Partnership NHS Trust** 2. **[redacted], widow of the Deceased** 3. **Care Quality Commission** 4. **Chief Coroner**
1	**CORONER** I am Dr. Peter Harrowing, LLM, Assistant Coroner, for the coroner Area of Avon
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 22nd April 2014 I commenced an investigation into the death of Mr. Masoud Ghaderi age 54 years. The investigation concluded at the end of the inquest on 11th June 2015. The conclusion of the jury was that the medical cause of death was I(a) Hanging and the conclusion as to the death was that of "Suicide. Insufficient communication, documentation and staffing led to inadequate overarching care, creating an environment in which Mr. Ghaderi was able to take his own life".
4	**CIRCUMSTANCES OF THE DEATH** From around August 2013 Mr. Ghaderi suffered from a depressive episode. He was initially treated by his general practitioner and prescribed antidepressants and then referred to a consultant psychiatrist. However, during November and December 2013 Mr. Ghaderi, who suffered with diabetes mellitus, took an overdose of insulin on three occasions on each of which he required hospital admission. Following the third overdose of insulin on 26th December 2013 Mr. Ghaderi was further assessed by the mental health team and on 31st December 2013 he was admitted as an informal patient to the Lime Unit, Callington Road Hospital, Bristol. [redacted], Consultant Psychiatrist, told the Inquest that had Mr. Ghaderi not agreed to an informal admission to hospital or had later sought to leave the hospital without permission he would have been assessed under the Mental Health Act 1983 for formal admission. On admission Mr. Ghaderi was noted to be suffering with a severe depressive episode and his mood remained generally low throughout his admission. There was concern with regard to his risk of suicide although despite having constant suicidal thoughts Mr. Ghaderi denied any intention to act on those thoughts. However, on 11th February 2014 the nursing staff questioned him with regard to a red mark around his neck. Mr. Ghaderi admitted he had tied his phone charger cord around his neck and said he did so to see what it was like. [redacted] remained concerned with regard to her husband's mental health particularly with regard to statements he made to her which she interpreted as being an indication of his suicidal intent. She told the Inquest that she had voiced those concerns to [redacted] and other members of staff on Lime Unit. On 3rd April 2014 Mr. Ghaderi underwent a session with [redacted] Consultant Psychologist. During that session Mr. Ghaderi made reference to there being two weeks before everything would be resolved. [redacted] considered that he may have been referring to the resolution of financial matters which had continued to cause

	him concern. However, Mr. Ghaderi left the session abruptly and avoided any questions with regard to any suicidal intent. As a result [redacted], who had observed a marked change in Mr. Ghaderi's mood and level of engagement, believed Mr. Ghaderi could have been referring to plans to take his own life. In evidence [redacted] stated that she advised the nurse in charge of her concerns and the heightened risk of suicide. However, [redacted] could not recall having that conversation with [redacted] During the morning of 10th April 2014 [redacted] was carrying out routine observations and went to Mr. Ghaderi's room at 11:06 hours. He had last been seen at 10:40 hours that morning on Lime Unit by Health Care Assistant [redacted]. [redacted] looked through the observation window into the room and saw Mr. Ghaderi apparently standing and facing the door of his ensuite bathroom. She noted the bedroom light was off and the curtains were drawn. As she entered the room she discovered that Mr. Ghaderi was hanging by a belt from door of the bathroom. Assistance was immediately summoned and resuscitation attempted. The emergency services arrived shortly afterwards and Mr. Ghaderi was taken to the Bristol Royal Infirmary and he was admitted to the Intensive care Unit. Mr. Ghaderi did not recover and life support was withdrawn with the agreement of the family. He was pronounced dead at 13:47 hours on 12th April 2014.
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. The **MATTERS OF CONCERN** are as follows. – (1) There was inconsistence records of engagement with service users. The Engagement and Observation policy of the Trust should be reviewed to consider how the policy operates and how engagements with service users are to be recorded in a consistent manner with appropriate staff training in application of the policy. (2) There was no one member of staff with overarching responsibility for reviewing any risk assessments. Therefore any trends in changing risk, e.g. increasing risk of self-harm or suicide, could not be identified. The Trust should consider designating a member of staff with this responsibility in the same manner as it has one member of staff with responsibility for ensuring the care plan(s) are reviewed and maintained up-to-date. (3) The Trust has a comprehensive single care record for each service user. However, the ward rounds rely only on a brief summary prepared by a nurse the night before when that nurse may not have made any entries in the care record nor would be present at the ward round. The Trust should review its planning and preparation for ward rounds so that reliance is not placed solely on a brief summary with the inherent risk of errors and omissions .
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 10th September 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 [redacted] widow of the deceased, and the Care Quality Commission. I shall send a copy of your response to [redacted] and the Care Quality Commission.

	I have sent a copy of my report to the Chief Coroner. 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	**17th July 2015** **Assistant Coroner**