REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Chief Executive, Pennine Care NHS Foundation Trust.
1	**CORONER** I am Ms L J Hashmi, Area 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 the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 3rd November 2015, I commenced an investigation into the death of **Guy Jeffrey Robinson.**
4	**CIRCUMSTANCES OF DEATH** Guy was a 31 year old man with enduring mental and physical health problems. He had been diagnosed as suffering from i) emotionally unstable personality disorder, ii) moderate depression, iii) post-traumatic stress disorder and iv) opiate dependence syndrome. The deceased had a tendency to self-harm and suffered periods of suicidal ideation, usually linked to life events and emotional instability. Furthermore, his physical health problems exacerbated his mental illnesses, increasing his anxiety levels. His ill-health resulted in frequent psychiatric inpatient episodes. Being 'AWOL' and absconding were not unusual for Guy, even when 'under section'. On the 7th May 2014, Guy was admitted as an informal patient on the mental health unit. On the 21st June 2014 he was compulsorily detained under Section 5 (2); this was subsequently regraded to compulsory detention under S2 MHA on the 23rd June 2014. Guy was 'under section' at the time of his death. His Responsible Clinician had granted S.17 leave, which had been increased over time. On the evening of the 10th July 2014 Guy left the ward on S.17 leave but failed to return when expected. The 'AWOL' protocol was not put in place immediately, rather some 2.5 hours later, as staff took steps to search the hospital and grounds in accordance with what was said to be an agreed local protocol with police. The Police were called at around 21:13 on the 10th July and following extensive searches in accordance with the Force's missing person protocols over the next few days, Guy was found deceased outdoors in undergrowth, on the evening of the 15th July 2014. A post mortem examination and toxicology were conducted. At inquest, a jury found the cause of death to be: 1a) Multiple drug toxicity 2) Exposure

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 'AWOL' protocol was not applied appropriately/in a timely manner and during the course of the evidence it became apparent that some of clinicians lacked familiarity with the protocol and process. Whilst the Trust has taken steps to ensure that the protocol has been discussed with all staff based on the ward in question, action has not been taken Trust-wide to ensure that all staff are fully familiar with this policy. 2. Clinical Psychology Service - the only access afforded to a Clinical Psychologist depends upon three pre-requisites being met - i) discharge ii) to a fixed abode iii) onward referral by the Community Mental Health Team. There is no inpatient Clinical Psychology facility and no ability for hospital clinicians to refer a patient directly. This is a significant service gap and potentially prejudices/puts at risk some of the most vulnerable people e.g. those who are of no fixed abode.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 the 7th January 2016. 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 - Pennine Acute Hospitals NHS Trust - GMP - CQC - NHS England 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: 12th November 2015 Signed: L J Hashmi