REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

<table>
<tr><td></td><td>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. Rt Hon Teresa May, Home Secretary, The Home Office, 2 Marsham Street, London SW1P 4DF
2. Rt Hon Jeremy Hunt, Secretary of State for Health, Department of Health, Richmond House, 79 Whitehall, London SW1A 2NS
3. Mr Andrew Foster, Chief Executive, Wrightington Wigan & Leigh NHS Foundation Trust, Royal Albert Edward Infirmary, Wigan Lane, Wigan WN1 2NN
4. Mr Ian Hopkins, Chief Constable, Greater Manchester Police, Central Park, Northampton Road, Manchester M40 5BP</td></tr>
<tr><td>1</td><td>CORONER

I am Alan Peter Walsh, HM Area Coroner for the Coroner Area of Manchester West</td></tr>
<tr><td>2</td><td>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.</td></tr>
<tr><td>3</td><td>INVESTIGATION and INQUEST

On the 16th February 2015 I commenced an investigation into the death of Joyce Carney, 81 years, born 8th February 1934. The investigation concluded at the end of the Inquest on 23rd March 2016.

The medical cause of death was
1a Acute Bronchitis, Renal Failure and General Debility
1b A combination of fractured neck of femur (operated), insulin dependant Diabetes, Myocardial Scarring and Vascular Dementia

The conclusion of the Inquest was Joyce Carney died as a consequence of a combination of naturally occurring disease and injuries, together with the treatment of the injuries, sustained when she was knocked to the floor in the corridor of a hospital by another patient, who was running away from Police Officers in an attempt to leave the hospital.</td></tr>
<tr><td>4</td><td>CIRCUMSTANCES OF THE DEATH

1. Joyce Carney (hereinafter referred to as "the Deceased") died at the Royal Albert Edward Infirmary Wigan on 11th February 2015.</td></tr>
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2. On the 20th December 2014 the Deceased, who was known to suffer with naturally occurring Insulin Dependent Diabetes Mellitus and Dementia, was admitted to the Royal Albert Edward Infirmary, Wigan with low blood sugars, Acute Kidney Injury and Urinary Tract Infection. She was transferred from the Emergency Department at the Hospital to Lowton Ward in the Hospital later the same day.

3. On the 21st December 2014 another Patient (hereinafter referred to as "the Patient") was admitted to Lowton Ward at the Hospital under the observation of Police Officers pending a Mental Health Assessment but the Patient was not under arrest by the Officers, although the Officers were under instructions to arrest the Patient if he attempted to leave the Hospital.

4. At or about 20.40 hours on the 21st December 2014 the Deceased went to the toilet, which was situated off a corridor on Lowton Ward at the Hospital and, shortly after leaving the toilet, the Deceased was knocked to the floor in the corridor when the Patient, who was being observed by the Police Officers, collided with her whilst running away from the Officers and attempting to leave the Hospital.

5. The Deceased sustained a fractured neck of femur when she was knocked to the floor and she had surgery to repair the fracture on the 24th December 2014, after which she suffered with chest and urinary tract infections treated with antibiotics. She deteriorated on the 9th February 2015 and she died on the 11th February 2015.

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. During the Inquest evidence was heard that:-

   i. When the Patient was moved to Lowton Ward in the Hospital the risk assessment conducted by the Hospital in relation to the location of the Patient in the Ward involved the Bed Manager, the Ward Manager and the Nurses treating the Patient. The risk assessment did not involve, nor include, the Police Officers who were observing a patient. The risk assessment conducted by the Hospital focussed on the safety of the Patient and did not extend to the safety of other patients in the Hospital, visitors to the Hospital, members of the public and members of staff employed in the Hospital.

   ii. The risk assessment conducted by Police Officers, in relation to the Patient at the Hospital, focussed on the Patient and the fact that

the Patient may seek to leave the Hospital but the assessment did not include any discussions or liaison with Hospital staff. The risk assessment did not include the protection of other patients in the Hospital, visitors to the Hospital, members of the public or staff employed in the Hospital.

iii. There was no liaison or communication between the Police Officers observing the Patient and the Hospital treating the Patient in relation to the layout of the Hospital or with regard to the safety of other patients in the Hospital, visitors to the Hospital, members of the public and staff employed in the Hospital.

The lack of liaison led to Police Officers believing that a fire escape existed at the end of Lowton Ward and to the side of the Patient's bed, which had to be protected to prevent the Patient leaving the Hospital. The Officers believed that the fire escape involved a 20 to 30 foot drop from the 2nd floor of the Hospital onto an open area outside the Hospital building, which could be used to leave the Hospital or to commit self-harm. In fact the evidence at the Inquest established that the fire escape was not a fire escape but simply a fire exit into a corridor leading into another Ward within the Hospital without any exit door or exit from the building. Focus upon the fire exit and a belief that there was an exit in the corridor led to the Police Officers making a decision to sit on one side of the Patent's bed, and at the foot of the bed, leaving the side of the bed facing the exit to the Ward open for the patient to leave the Hospital.

Furthermore the Officers at the Hospital raised concerns with their Supervising Officer, namely a Sergeant at the Police Station, in relation to the Patient being agitated and threatening to leave the Hospital during the afternoon of the 21st December 2014 but neither the Sargent nor any other senior Officer attended the Hospital to conduct any further risk assessment or to reassess the situation.

iv. There are no agreed protocols, policies or procedures between the Greater Manchester Police and the Royal Albert Edward Infirmary, Wigan in relation to joint risk assessments for patients detained at the Hospital under arrest or in the presence of or supervised by Police Officers. Furthermore there is no protocol, in relation to liaison and consultation between the Greater Manchester Police and the Hospital to formulate risk assessments in relation to patients detained at the Hospital under arrest or in the presence of or supervised by Police Officers.

During the course of the evidence it was accepted that risk assessments conducted by either the Police or the Hospital, and any joint risk assessments, should focus upon the Patient but the assessments should also include the protection of other patients in the Hospital, visitors to the Hospital, members of the public and staff employed in the Hospital.

v. The evidence at the Inquest indicated that the absence of protocols, policies and procedures in relation to joint risk assessments as between the Police and Hospitals is likely to arise in relation to the detention of patients in many Hospitals in the United Kingdom where patients are detained under arrest or in the presence of or supervised by Police Officers.

vi. The evidence at the Inquest accepted that, if the Patient had not been able to attempt to leave the Ward in the Hospital, the Deceased would not have suffered the injury, which contributed, to the cause of her death.

vii. At the Inquest it was accepted by the Police and the Hospital that patients are taken to the Royal Albert Edward Infirmary, Wigan on a weekly basis under arrest or in the presence of or supervised by Police Officers and on many occasions a patient, in the presence of the Police, is admitted to a Ward in the Hospital from the Emergency Department. Accordingly, a risk assessment in relation to the location of a patient in the presence of the Police, either in the Emergency Department or in a Ward, is an important factor in risk assessments to protect other patients in the Hospital, visitors to the Hospital, members of the public and staff employed in the Hospital, particularly if the patient is known to be violent or the patient has a previous history of sexual offences. Such matters may only be within the knowledge of the Police and liaison between the Hospital and the Police is critical to enable such information to be considered within the risk assessment and to enable the Police to be aware of the layout of the Hospital.

viii. The evidence raised concerns that there is a risk that future deaths will occur in similar circumstances to the Deceased, and in other circumstances, unless action is taken to review the above issues.

2. I request the Greater Manchester Police and the Wrightington Wigan and Leigh NHS Foundation Trust to consider the above concerns in relation to Hospitals under the management of the Wrightington Wigan and Leigh NHS Foundation Trust and I request the Greater Manchester Police to further consider the concerns in relation to all Hospitals in the Greater Manchester area.

   I also request the Home Secretary and the Secretary of State for Health to consider the above concerns in relation to all Hospitals in the United Kingdom.

   I request the Home Secretary, the Secretary of State for Health, the Greater Manchester Police and the Wrightington Wigan and Leigh NHS Foundation Trust to carry out reviews with regard to the following:-

   i. The security of patients under arrest or in the presence of or supervised by Police Officers in any location within a Hospital.

ii. The protection of other patients in the Hospital, visitors to the Hospital, members of the public and staff employed in the Hospital whenever a patient is detained under arrest or in the presence of or supervised by Police Officers in any location within a Hospital.

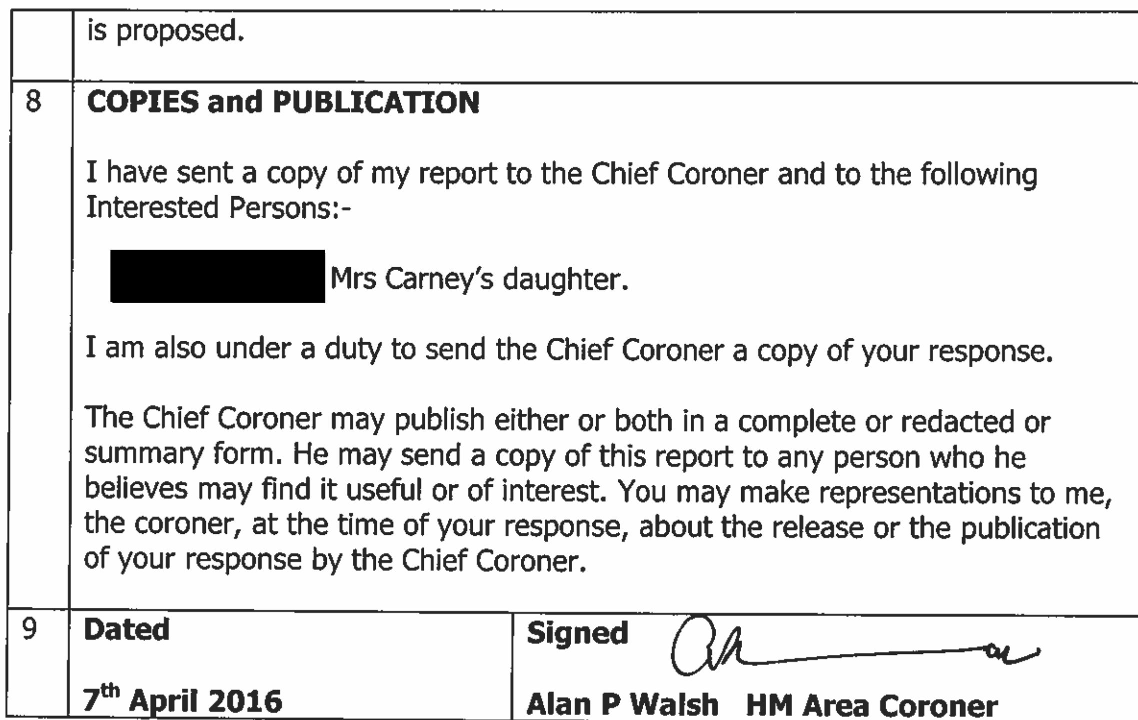
iii. The provision of protocols, policies and procedures as between Police Forces and Hospital Trusts in relation to the formulation of joint risk assessments and the inclusion of liaison and consultation between Police Forces and Hospital Authorities in the formulation of joint risk assessments in relation to patients detained at a Hospital under arrest or in the presence of or supervised by Police Officers.

The purpose of the protocols, policies and procedures would be to protect the individual patient detained by the Police and to consider and protect other patients in the Hospital, visitors to the Hospital, members of the public and staff employed in the Hospital.

The Home Secretary and the Secretary of State for Health would be in a position to bring the concerns to the notice of all Police Forces and Hospitals in the United Kingdom to enable the concerns to be considered in individual areas or regions as between individual Police Forces and individual Hospital Trusts on a nationwide basis. It is accepted that some Police Forces and Hospital Trusts may already have appropriate protocols, policies and procedures in place but the evidence at the Inquest was that they did not exist in many Hospitals in the United Kingdom.

The need for a review both in Greater Manchester and on a nationwide basis when a patient is detained at a Hospital under arrest or in the presence of or supervised by Police Officers relates to the fact that there are special considerations in relation to risk assessments in relation to such patients that do not arise in relation to patients who are not detained under arrest or in the presence of or supervised by Police Officers.

6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and your organisation 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 2nd June 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:- Mrs Carney's daughter. 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	**Dated** **7th April 2016** | **Signed** **Alan P Walsh HM Area Coroner**