REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Elizabeth McManus, Chief Executive, North Middlesex University Hospital NHS Trust, Sterling Way, London, N18 1QX**
1	**CORONER** I am Nadia Persaud, Senior Coroner for the area of Eastern Area of Greater London
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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 2nd January 2015 an investigation was commenced in the death of Joshua Knox-Hooke. The investigation concluded at the end of the Inquest on the 28th July 2016. The conclusion of the Inquest was a narrative conclusion: *Joshua Knox-Hooke was taken by ambulance to A & E at North Middlesex Hospital on the 1st December 2014. He had lacerated his neck and wrist and reported that he had wanted to kill himself. A & E staff were aware of the history of psychosis and recent drug use. Despite this presentation he was not kept within eyesight pending a psychiatric assessment. He left the hospital before a psychiatric assessment was carried out. He was not seen or heard from until 28th December 2014. On the 28th December 2014 he was found deceased partly immersed in the Banbury reservoir. He died as a result of drowning. There was a failure by A & E staff on the 1st December 2014 to comply with the policy in place to ensure that Mr Knox-Hooke should be kept within eyesight of staff at all times.*
4	**CIRCUMSTANCES OF THE DEATH** Joshua Knox-Hooke was a 22 year old man. He had no history of mental illness prior to 2014. In July 2014, he travelled to Thailand and whilst on his travels suffered an acute psychotic episode. He returned to the UK on the 17th October 2014 where the diagnosis of affective psychotic episode was made. He came under the care of the mental health services provided by Barnet, Enfield and Haringey Mental Health NHS Trust. He was compliant with his mental health care and attended appointments as required with psychiatrists, care co-ordinator and psychologist. He was also compliant with medication. On the evening of the 30th November 2014, Joshua left home and told his brother that he wanted to die. He returned at 05:30 on the 1st December 2014 and during the morning of the 1st December 2014 he used a kitchen knife to cut both sides of his neck and wrist. He was taken by ambulance to the North Middlesex Hospital A & E. He was triaged by a nurse who noted that he had smoked crack cocaine the previous night and on returning home had cut himself with a kitchen knife causing lacerations to both sides of his neck and wrist. The paramedic staff handed over that Mr Knox-Hooke suffered from psychosis. They also handed over that when asked he stated that he wanted to kill himself. Mr Knox-Hooke also responded to a question by A & E staff to

	confirm that he wanted to kill himself. Mr Knox-Hooke was taken to the mental health bay. The triage nurse later saw him walking towards the x-ray department / exit. She asked where he was going. He said that he wanted a drink of water and she escorted him back to the cubicle and provided a cup of water. No steps were taken to ensure that Joshua was kept within eyesight at all times. He was captured on CCTV leaving the hospital at 11:38. There is no evidence available to suggest that he was seen leaving the hospital by any member of staff. There is no evidence to suggest that he was encouraged to remain within the unit or to expedite the psychiatric assessment.
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. – My findings of fact included the following:- 1. I was informed that the Trust policy in place in December 2014 required a patient presenting with a current attempt at self-harm and suspected drug use to be nursed in an observable area AND to be kept within eyesight at all times. The evidence revealed that Joshua was not kept within eyesight at all times. 2. The evidence revealed that *it is common for patients to leave the North Middlesex A & E prior to psychiatric assessment.* This was confirmed by the triage nurse in her oral evidence and also stated within the Root Cause Analysis Investigation Report of Barnet, Enfield and Haringey Mental Health NHS Trust. 3. The triage nurse who gave evidence during the course of the Inquest did not consider that it would be possible to make a patient to remain within the hospital for their own safety. She was unaware of the nurses holding power under Section 5.4 of the Mental Health Act. 4. The North Middlesex University Hospital NHS Trust did not consider this matter to fall within their criteria for a Serious Incident. No Serious Incident Investigation was carried out. 5. The consultant psychiatrist who gave evidence at the Inquest Hearing confirmed that had Joshua been referred to him on the morning of the 1st December 2014, the presentation at that time would have resulted in him being admitted to hospital (with or without his consent).
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 the **26th September 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, [redacted] (mother of Mr Knox-Hooke) and to the CQC. I have also copied the report to the relevant Director of Public Health [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 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	1st August 2016 **[SIGNED BY CORONER]**