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. **Bristol Clinical Commissioning Group**
2. **Avon & Wiltshire Mental Health Partnership NHS Trust**
3. **[redacted] father of the Deceased**
4. **Care Quality Commission**
5. **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 8th December 2015 I commenced an investigation into the death of Mr. Rohan Fitzsimons age 21 years. The investigation concluded at the end of the inquest on 20th July 2016. The conclusion of the jury was that the medical cause of death was I(a) Multiple Injuries and the conclusion as to the death was that of **Suicide**.

4 CIRCUMSTANCES OF THE DEATH

From around July 2014 concerns were raised with regard to the behaviour of the Deceased and in October 2014 he was admitted to hospital in Hertfordshire under S.2 Mental Health Act 1983. On 7th March 2015 he was again admitted to hospital in Hertfordshire under S.2 Mental Health Act 1983 and at that time a diagnosis of drug-induced psychosis was made.

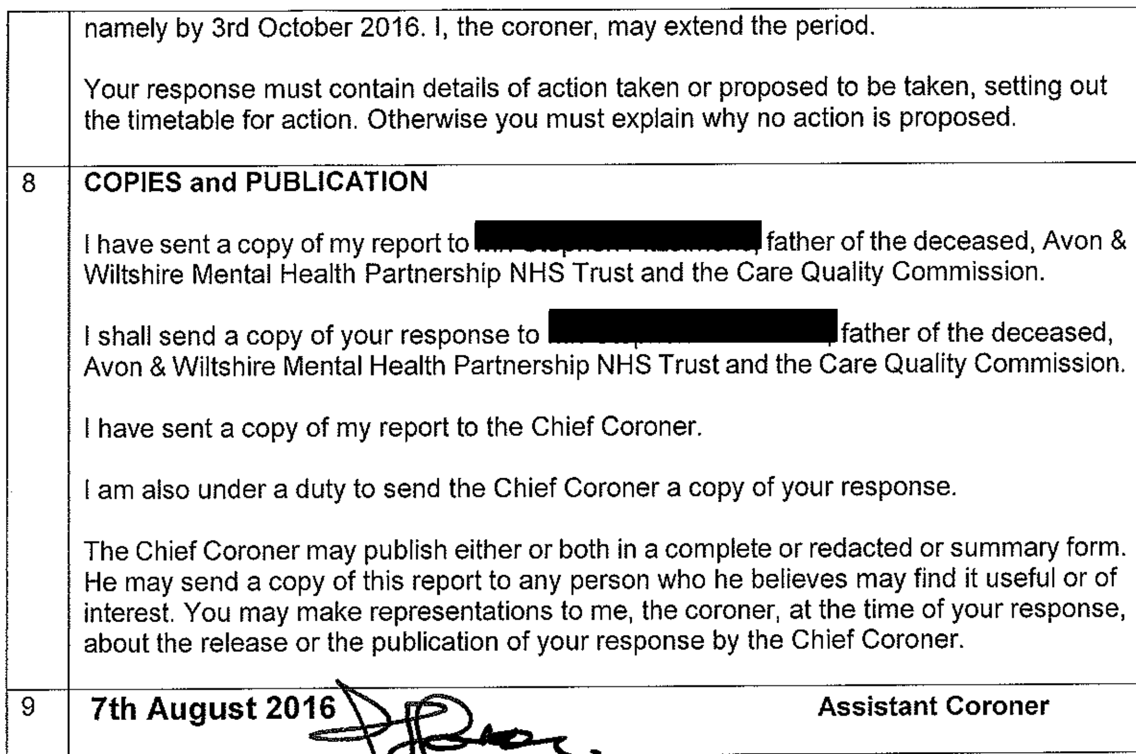
Following discharge from hospital on 1st April 2015 he was referred to the Bristol Crisis Team to support his transition from the ward to his home in Bristol. He was later transferred to the care of the Early Intervention Team. He was accepting of medication and agreed to the input of a support worker. However, towards the end of April 2015 he began missing appointments with the community team. His family became concerned with regard to his obtaining accommodation and his finances. In July 2015 his family thought he had stopped taking his medication and was displaying paranoid behaviour. When they were unable to contact him they reported him as a missing person. The community team saw him the following day and he was noted to be unwell, dishevelled, describing delusional ideas and neglecting himself.

Engagement with the community team over the following few weeks was sporadic and there was evidence the Deceased's mental state was continuing to decline. In October 2015 it was discovered he had caused significant damage to his property and was facing eviction.

On 18th October 2015 the Deceased was assessed by the Crisis Team due to concerns over his mental state. The following day, the 19th October 2015, he was seen by the registered mental health nurse from the Early Intervention Team together with a consultant psychiatrist as a result of which it was determined he met the criteria for a Mental Health Act Assessment. This was discussed with the Approved Mental Health practitioner who advised there were no beds available. The Inquest heard evidence that since there was no bed available the Mental Health Act Assessment was not carried out and that is was usual practice not to carry out such an assessment unless and until a bed was available.

On 23rd October 2015 a bed had become available and the Deceased underwent a Mental Health Act Assessment and was detained under S.2 of the Act on the Silver Birch

	Unit, Callington Road Hospital. The Deceased was diagnosed with schizophrenia and was prescribed antipsychotic medication. Whilst on the Silver Birch Unit concerns were raised that the Deceased may not have been taking his medication and he displayed violent and aggressive behaviour. Owing to this behaviour it was necessary to transfer him to the Hazel Unit and intensive care facility at Callington Road Hospital. He was transferred back to the Silver Birch Unit on 9th November 2015. Prior to the expiry of the S.2 period of detention the Deceased was further detained under S.3 of the Act. Following his return to the Silver Birch Unit the Deceased became more settled and he was granted leave in accordance with S.17 Mental Health Act 1983 on a staged basis. The leave periods progressed well until he was allowed unescorted community leave twice daily for one hour. On 23rd November 2015 the Deceased was late returning from leave. However, he attended a Police station in Bristol and contacted the Silver Birch Unit to advise them he would be late. No concerns were raised with regard to this late return and on 24th November 2014 it was agreed he could have unescorted leave twice daily for a period of two hours on each occasion. All of the staff from the Silver Birch Unit who gave evidence stated that throughout his time at the hospital the Deceased had never indicated he had thoughts of self-harm or an intention to take his own life. On 25th November 2015 he was signed out from the Unit at around 11:00 a.m. for his two hour period of unescorted leave. At around 15:00 hours the Police telephoned the Unit to advise that the Deceased had been seen to jump from the Clifton Suspension Bridge at around 12:30 hours and had been fatally injured. The Deceased was pronounced dead at 14:42 hours on 25th November 2015 at The Portway, Bristol
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) The Avon & Wiltshire Mental Health Partnership NHS Trust (AWP) told the Inquest that the provision of in-patient beds is subject to the funding provided by the Bristol Clinical Commissioning Group (CCG). (2) The Inquest heard evidence that no Mental Health Act Assessment was carried out on the Deceased when it was determined to be necessary because no bed was available and that this was a situation which commonly occurred. (3) In the case of the Deceased the assessment was not performed until four days after it was deemed necessary and was only carried out once a bed was available. Whilst the Inquest did not hear evidence to indicate that the delay in carrying out the Mental Health Act Assessment contributed to the Deceased taking his own life it must follow that in some circumstances such a delay could lead to an individual taking their own life before the assessment was performed and a bed was made available. (4) The CCG should review urgently its commissioning of in-patient mental health beds so as to ensure, in so far as reasonably practicable, that a bed is available when a person who satisfies the criteria for a Mental Health Act Assessment needs to be detained following that assessment. The CCG should work with AWP in carrying out this review and determine what action can and should be taken when a person who satisfies the criteria for a Mental Health Act Assessment needs to be detained following that assessment but no bed is available. If a person meets the criteria for a Mental Health Act Assessment such an assessment should be carried out promptly and not be delayed for an indeterminate period owing to a lack of beds.
6	**ACTION SHOULD BE TAKEN** I 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 3rd October 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 [redacted] father of the deceased, Avon & Wiltshire Mental Health Partnership NHS Trust and the Care Quality Commission. I shall send a copy of your response to [redacted] father of the deceased, Avon & Wiltshire Mental Health Partnership NHS Trust 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	**7th August 2016** **Assistant Coroner**