	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **Head Legal Services and Claims, Tees, Esk and Wear Valley NHS Foundation Trust, Central Resources, Lanchester Road Hospital, Lanchester Road, Durham DH1 5RD**
1	**CORONER** I am Crispin Oliver Senior Assistant Coroner, for the Coroner area of County Durham and Darlington
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. (see attached sheet)
3	**INVESTIGATION and INQUEST** On 17th August 2015 I commenced an investigation into the death of Michael Peter McMonigle, ("Michael") born 25th October 1969. The investigation concluded at the end of the inquest on 8th August 2016. The conclusion of the inquest was Suicide, contributed to by neglect. The jury stated made the following entries in Boxes 3 and 4 of the Record of Inquest, including a narrative on key issues in Box 4: Box 3: Michael McMonigle was admitted at a voluntary patient to the Farnham Ward at Lanchester Road Hospital on 5th August 2015. Michael was able to leave the hospital unaccompanied on 11th August 2015, leading to his death on 11th in woodland at Trinity School, Trout Lane, Lanchester, Co. Durham by suspension by ligature and was declared dead at 07:35 hrs on 12th August 2015. On the balance of probabilities the jury concluded that the admitted failure of not updating the face risk assessment, PARIS case notes and intervention plan with the assessment of risk of self-harm or suicide and the conditions for escorted leave made at a formulation meeting on 10th August 2015 probably more than minimally or trivially contributed to Michael's death. The manner and extent that Michael's family were informed of the assessment of risk and the conditions for escorted leave following the formulation meeting on 10th August probably more than minimally or trivially contributed to Michael's death. The manner in which the handover to his family was prepared for and conducted when Michael left the ward on 11th August 2015 probably more than minimally or trivially contributed to Michael's death. Finally, the lapse of time between Michael leaving the hospital on 11th August 2015 and when it was recognised he might be a missing patient probably more than minimally or trivially contributed to Michael's death. Box 4: In conclusion Michael's death was caused by suicide whilst the balance of his mind was disturbed. His death was contributed to by neglect. Due to inadequate communication of potentially significant information between Michael's family and staff members, Michael was put at significant risk on 11th. Trust leave policy was not fulfilled to a satisfactory level and staff knowledge of policy, particularly from the Consultant Psychiatrist was unsatisfactory. Whilst the jury thought that the policy was adequate, the failure of staff to recognise and fulfil all aspects of the policy was severely lacking and probably more

	than minimally or trivially directly contributed to Michael's death. Appendix 3 Missing Patient report completed after Michael was found to be missing the jury held to be lacking in that not all initial actions deemed vital were fulfilled. They heal it evident that there were several occasions prior to 22:00hrs where the alarm of Michael's absence could have been raised particularly from 19:20 to 21:00 hrs. Finally the effect that business and staff pressure had on the leave and death of Michael on 11th August was a contributing factor to Michael's death of note, the lack of handover to Michael's parents on 11th by the Acting Ward Manager which did not fulfil the Trust policy best practice and was therefore insufficient.
4	**CIRCUMSTANCES OF THE DEATH** Michael Peter McMonigle ("Michael") was admitted between 23rd June and 23rd July 2015 into Lanchester Road Hospital, Farnham Ward (an acute mental health ward) as an informal patient. He was re-admitted on 5th August 2015 as an informal patient. Until 10th August 2015, formulation meeting, he was assessed as being suitable for unescorted leave. At the formulation meeting on 10th September 2015 his risk of self-harming was assessed as "significant" and the conclusion was that he should not have leave off the ward unescorted. The conclusion of the formulation meeting was documented in Michael's PARIS case notes. Otherwise it was conveyed to nursing ward by word of mouth at morning report out meetings and shift handovers. Such information as was conveyed to Michael's parents from the formulation meeting was by the Consultant Psychiatrist immediately afterwards in a brief informal meeting in an adjacent room. Michael had not wanted his parents to attend the formulation meeting itself. The evidence of Michael's mother was that the information was conveyed to her by being present when the Consultant Psychiatrist said to Michael that he should not "go off the ward without your mum". She said that the background reasoning and analysis as to risk levels were never conveyed to her. The following day, 11th August 2015, Michael left the ward with his mother. Ward staff were unable to confirm which of them had attended at the handover and let them out of the ward. The mother recalled that it was the Acting Ward Manager. There was a policy in place," Policy for Leave from Hospital and Leave of Absence under Section 17 of the Mental Health Act 1983" (policy number CLIN0025) pertaining to informal patients. The evidence of the Consultant Psychiatrist was that there was no such policy. However, his evidence was contradicted by other ward staff and indeed the production during the course of the inquest of the policy document. No formal assessment was undertaken by ward staff of Michael's condition on handover. They did confirm that he had interacted with staff during the course of the morning and appeared to be in a comparatively positive state. Michael's mother concurred that there had been no formal assessment at the handover, further that she did not receive a briefing as to his heightened state of risk identified that the previous day`s formulation meeting, or the reasons for leave to be accompanied. After a period of accompanied leave off ward in the hospital cafeteria and the car park and grounds of the hospital, Michael's parents left Michael in the cafeteria of the hospital. Michael's mother gave evidence that had she known of the heightened risk and if she had been properly briefed, she would never have left Michael alone off ward. Her precise words were she would have "stuck to him like glue". Michael left the cafeteria and the hospital at some time after 14:30 hrs on 11th August 2015. He did not return. Ward staff did not become concerned about his whereabouts until, at the earliest, 22:00hrs. Ward staff in their evidence agreed that it may have been available to conclude that there was a problem from 19:20 hrs which was the evening shift handover time, and thereafter at 21:00hrs, the normal time for returning from leave. A missing patient report states that it was from 22:00hrs on 11th August that concern commenced as to Michael's whereabouts. Further that it was at 22:30hrs that staff contacted Michael's parents. It was Michael's mother's evidence that they were actually contacted 23:15hrs. The evidence from ward staff was that a search was not undertaken in the building and grounds of the available CCTV footage of the reception, entrance, car park or other grounds. Michael was reported missing to the

	Police at 23:55hrs, according to the evidence of the Police Officer. Michael was found on 12th August 2015, being suspended by a ligature, the call being made to paramedics at that time. He was declared dead at the scene.
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 lack of knowledge of the policy for leave for informal patients amongst ward staff and the Consultant Psychiatrist in particular. (2) The failure to follow the policy in terms of conducting an assessment prior to the handover. (3) The failure to apply the policy in terms of ensuring that leave arrangements are clearly understood by the patient and communicated to relatives. See paragraphs 6.7 and 6.8, the policy of Leave from Hospital and Leave of Absence under Section 17 Mental Health Act 1973, policy no CLIN00025. (4) The Face risk assessment, PARIS case notes and intervention plan were not updated with assessment of risk of self-harm and suicide and details of conditions for escorted leave following the formulation meeting on 10th August 2015. Instead, it fell to staff to verbally convey this information to colleagues who had not attended at the formulation meeting and to members of the family. (5) Failure to respond to Michael's absence until well after 19:20 hrs, when it was admitted by ward staff in evidence that interventions could have been commenced, alternatively 21:00hrs when it was conceded that the alarm could have been raised given that that was the normal time for return from leave. (5) The response to Michael's absence did not conform with paragraphs 7.3 of the Missing Patients Procedure, ref. CLIN-0006-V4 in that there was no search of the hospital internally, a search of the grounds, enquiry with other staff users, check of CCTV footage. (6) The following responses were undertaken after 19.20 and 21.00 when in conclusion of the jury the alarm could have been raised: enquiry with friends or relatives from 22:30hrs at earliest, an attempt to telephone Michael from 22:40 hrs at earliest, contact with relatives from 22:30 hrs at the earliest (Michael's mother said 23.15), Police at 23:45hrs at the earliest, other hospital staff at 00:15hr on 12th August at the earliest, the medical staff at 12:20hrs at the earliest. Staff knowledge of the Leave policy and Missing Patients Procedure was inadequate.
6	**ACTION SHOULD BE TAKEN** In my opinion 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 10th 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 the Chief Coroner. I have also sent it to [redacted] who may find it useful or of interest. 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**.....15/8/16..... **Signed**.....C A Oliver..... **CRISPIN A OLIVER M.A.** **H M Assistant Coroner for** **County Durham and Darlington**