REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Kent & Medway NHS & Social Care Partnership Trust**
1	**CORONER** I am Patricia Harding, senior coroner, for the coroner area of Mid Kent & Medway
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 27th April 2015 I commenced an investigation into the death of Natalie Gray,24 years. The investigation concluded at the end of the inquest on 1st November 2016. The conclusion of the inquest was suicide contributed to by neglect where there were gross failures resulting from: 1.Insufficient risk assessments on 17th, 20th and 21st April 2015 to highlight the risk of self harm 2. Inadequate MDT and nursing handovers on 21st April 2015 including omission of the requirement to reassess Natalie's informal status should her presentation change or should she attempt to self discharge 3. Failure to convey and enforce the correct procedures for informal patient leave to OT support workers 4. Failure by OT support workers to follow the leave procedure The following failures were found to have possibly contributed to the death: 1. A delay by staff at Priority House on confirming that it was Natalie who left Priority House and commencing a search 2. An unnecessary delay in the deputy ward manager reporting that Natalie was missing to Kent Police 3. A failure by the deputy ward manager to provide Kent Police with relevant information 4. A failure by the deputy ward manager to follow Trust policy by not contacting Natalie's next of kin The following matters were found to be relevant to the circumstances of the death; 1. A failure by the Mental Health Trust to record third party information on 17th and 21st April 2015 2. By a majority of 9:2 a failure by the call taker and back up dispatch officer to elicit relevant information from the informant
4	**CIRCUMSTANCES OF THE DEATH** Natalie Gray was 24 years of age at the time of her death. On 21 April 2015 she left Priority House where she was an informal patient and made her way to Barming railway station where she remained on the station platform for two hours until a non-stopping train approached at which point she jumped in front of it causing multiple injuries from which she died. Natalie was diagnosed with an emotionally unstable personality disorder and had a number of previous admissions to mental health hospitals following attempts to take her life. Although her mental illness was longstanding, in 2015 Natalie's father was gravely ill, her daughter was removed from her care as Natalie was subject of a police investigation and her relationship with her partner with whom her daughter was living, ended. These individuals were all major protective features in Natalie's life. Natalie had

attempted to kill herself within a very short period of being discharged or self-discharging from hospital during the course of these events.
On 9 April 2015 she was admitted as an informal patient to Priority House after attempting to gas herself.
On 15 April 2015 she attended the funeral of her father and the following day was repeatedly heard to express quasi-psychotic thoughts and statements that she wanted to end her life.
On 17 April 2015 she left the facility and travelled to Maidstone Hospital where she expressed the same thoughts to a hospital chaplain. The chaplain reported the visit to staff at Priority House who failed to record the matter. Natalie was seen on a ward round after returning to the facility at which time she was told that her discharge was being planned. Although Natalie acknowledged that she had a good relationship with her care coordinator and was willing to engage with psychological therapy which had been planned for her some months before and was awaiting funding, it was evident that she was distressed about the proposed discharge and felt let down. She continued to express quasi psychotic thoughts.
On the evening of 20 April 2015 Natalie was found to be very agitated and demanded to see a doctor as she wanted to discharge herself having learned that her discharge was imminent. She told a psychiatrist that she wanted to leave before she was kicked out, that she felt abandoned as a result of her daughter being taken away from her, her partner not wanting to know and her father having died, she was a burden and couldn't see a way forward but wanted to go home to die. As with previous occasions Natalie gradually calmed down. The psychiatrist recorded that Natalie's informal status should be reassessed if she further became agitated and wanted to leave the facility. A short while later Natalie became agitated again asking to leave and stating she didn't want to live anymore. On this occasion she accepted medication and her observations were increased. She appeared settled throughout the night and the following morning.
Shortly after 15.00 on 21st of April 2015 Natalie was heard to be shouting and screaming in the ward corridor. She could not get into her room and was punching and kicking the door. After being let into her room by a nurse Natalie continued to be agitated. It was established that she wanted to speak to social services to arrange contact with her daughter. She eventually calmed down after the nurse spent some 20 minutes talking to her.
Natalie's aunt had telephoned the facility around this time as she was concerned for Natalie following a communication from her the previous evening. She was told that Natalie was fine. The telephone contact was not recorded
The nurse returned to her office leaving Natalie in her room and some 10 to 15 minutes later saw an OT support worker letting Natalie off the ward. It was another 5 to 8 minutes before the nurse went to make enquiries with the OT support worker as she was on the telephone with the relatives of another patient. The OT support worker was not aware that an informal patient had to be signed out by a nurse. It had become common practice for OT support workers to let informal patients off the ward to smoke in contravention of Trust policy.
As a result of insufficient and inaccurately recorded risk assessments and inadequate nursing and MDT handovers none of the staff working on 21 April 2015 save the deputy ward manager were aware that Natalie was a medium risk of self-harm which became high if she left the ward, nor were they aware that her informal status should have been reassessed in the circumstances under which she left the hospital.
Once it had been established that it was Natalie who left the facility a local search was conducted by two members of staff but that Natalie was missing was not reported to the police for some 30 to 40 minutes. When the police were contacted by the deputy ward manager he did not adequately convey relevant information about Natalie or her risk of self-harm andthe call takers from Kent Police did not seek to elicit relevant information which would have assisted in the classification of the call and the police response.

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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

	The **MATTERS OF CONCERN** are as follows. – Whilst it is recognised that a significant number of changes have been made by both the Mental Health Trust and Kent Police to procedures and protocols that were in place at the time of the death of Natalie Gray, a number of matters remain outstanding, are subject of continuing work or require clarification and as a result the following matters are of concern: (1) The approach to discharge planning has been addressed on a general basis but the pathway for those with a diagnosis of personality disorder is currently under review and has not been finalised. It remains a concern that a patient with an emotionally unstable personality disorder will meet the current criteria for discharge but shortly thereafter be at risk particularly where specialist therapies are planned but have not been approved/started (2) The risk assessment form has not yet been addressed and is under review, there remains an issue as to whether the risk is recorded as a present risk alone or includes chronic risk (particularly for those with personality disorders) as oppose to historic risk. Although risk is discussed at handovers and ward rounds there is no evidence that the risk rating is communicated or signed off by the doctor when the record is completed by a nurse/junior doctor (3) Kent Police and Kent & Medway NHS & Social Care Partnership Trust have agreed a Missing Person Procedure implemented 1st December 2015. There is a concern about the terminology for use in the risk assessment that the Mental Health Trust is required to complete which may lead to an inaccurate risk assessments. There appears to be no explanation as to whether the risk is that formally documented or the risk at the time the patient left the facility which may be less clear. Additionally the use of the term 'significant' is highly subjective, is it intended to mean a likely risk of self harm or something more. It is not clear how the Trust should deal with those likely to place themselves in danger and therefore at medium risk of self harm, in terms of the timescales involved and whether 999 should be used or not. By way of example, Natalie's documented risk was inaccurately recorded as low, when it should have been medium and on leaving the facility medium to high, this could lead to an underestimation of the risk of self harm depending on how the form is interpreted by staff. (4) Significant information from third parties was not recorded in the Rio notes when received or at all
6	**ACTION SHOULD BE TAKEN** 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 **14th March 2017**. 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 Kent & Medway NHS & Social Care Partnership Trust, Kent Police, [redacted] [redacted] I have also sent it to Care Quality Commission and NHS England 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	**[DATE]** **13th January 2017** **[SIGNED BY CORONER]**