REGULATION 28: REPORT TO PREVENT FUTURE DEATHS
David Knight deceased

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.Mr Jeremy Hunt, Secretary of State for Health** **2. The Chief Executive, NHS England**
1	**CORONER** I am Dr Elizabeth **Emma** Carlyon, Senior Coroner for the coroner area of Cornwall and the Isles of Scilly
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** **David Knight died on 23rd May 2015 and an inquest was opened on 4th June 2015. The inquest was held with a jury between the 14th – 17th June 2016 at Truro Municipal Buildings, Truro where they concluded the death was due to suicide.**
4	**CIRCUMSTANCES OF THE DEATH** **David Knight was detained under S3 of the Mental Health Act on 1st April 2015 due to deterioration in his chronic mental health issues (paranoid schizophrenia) which was exacerbated by non-compliance with prescribed medication and cannabis use. As there were no acute mental health beds available in Cornwall at that time, he was transferred to Cygnet Hospital, Kewstone, Western-Super-Mare for treatment (5 hours travel from his home in Cornwall). On the 21st May 2015 he was granted S17 leave to his parent's home in St Austell, Cornwall. He was picked up by his father from hospital on 21st May and taken to his house and appeared uncommunicative and his mental health appeared to deteriorate while on leave. On the 23rd May he disappeared sometime after 11.00 am from his parents address. At around 12.58 pm he was seen to walk and stand on the train track in front of an oncoming train on the Trenance Viaduct, St Austell. Despite the use of the emergency brakes, the train was unable to stop and it hit Mr Knight resulting in his death from multiple injuries.**
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. – At the inquest, evidence was given by the Cornwall Partnership Trust and Kernow Clinical Commissioning Group and the expert Psychiatrist that there was a national shortage of acute mental health beds necessitating the use of out of county placements for patients requiring hospitalization for their mental health treatment. In Cornwall in

	2015, the average out of placement was 6/7 patients per day but on occasions up to 20 patients. In the summer of 2015, there were between 30-40 patients per day placed out of County (due in part to renovation works on a local mental health hospital). S17 leave is prescribed by the Responsible Medical Officer as part of the treatment to the hospitalised patient in order facilitate them re-integrating back into the community in a structured, safe and supported way. Typically this would start off with escorted leave in the grounds of the hospital and hospital locality, moving to unescorted leave and then to home leave. Latterly the community mental health services and Home Treatment Team are involved to ensure a smooth transition of the patient back to community living. When Mr Knight's mental health deteriorated whilst on leave, there were concerns that a limited risk assessment was carried out by Cygnet Hospital prior to S17 leave on 21st May 2015 and there was no communication with the local community mental health team and Home Treatment Team in Cornwall notifying them of the leave. This meant that when Mr Knights mental health deteriorated while on leave, there was no method of reducing the risk of self-harm or harm to others, as no mitigation plan had been put in place in advance of the leave and the Cornwall Community Mental Health Team and the Home Treatment Team were unaware he was on S17 leave in their area. The expert psychiatrists considered that although misjudgement about leave could occur in any hospital setting, the fact that Mr Knight was being treated out of County would have increased the risk of poor communication with the community treatment teams as the hospital would not be familiar with local service and it was very likely that this had a bearing on Mr Knight's death ([redacted] The treatment of mental health patients generally includes the involvement of significant family, friends and pets. On Mr Knight's previous hospital admissions, his parents and dog has been considered at significant protected factors in preventing him self-harming and also aided in his recovery. Cygnet Hospital was a 5 hour drive from Mr Knight and his parent's home. This made it difficult to physically and practically arrange S17 leave and visiting by family/friends. There was also the cost of financing the visits. It was not possible (as on other admissions) due to the distance, for his dog to be included in the treatment plan [redacted] At the inquest the Consultant Psychiatrists (including Expert Psychiatrist) gave evidence that it was not best practice to treat patients out of county. This was particularly relevant to patients with chronic mental health issues (as with Mr Knight) where they were well known to the local mental health service and their needs and issue had successfully been addressed in the past [redacted] Another issues raised, was the difficulties of the "nearest relative" and the Responsible Medical Officer to adequately carry out their statutory function at such distances.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. To review the provision of acute mental health beds in Cornwall and the Isles of Scilly to avoid the continual routine requirement for "Out of County" placements (unless medically required). In particular to consider the rurality of Cornwall and the Isles of Scilly which makes it difficult for the commissioning service to locate acute mental health beds within acceptable travelling distance and/or cost of travel for relatives and friends to visit/transport. I have been provided with assurance from Cornwall Partnership NHS Foundation Trust and the Kernow Clinical Commissioning Group that they are addressing this issue from a local perspective and I attach a letter dated 1.7.16 detailing their actions. I understand though that this is a national issue [redacted]

	[redacted] and I considered that you should be aware of the matter raised at inquest with a view to preventing future deaths; in particular from Suicide. The Cornwall and Isles of Scilly Coroner Service is committed to reducing suicides and your reply will be fed back to the local forum "Towards Zero Suicides".
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 16 January 2017 *additional time allowed for the festive period. 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] of Hodge, Jones and Allen [redacted] Radcliffe's Brasseur (Cygnet Hospital), [redacted] (Kernow Clinical Commissioning Group). I have also sent it to [redacted] Public Health, Chair of "Towards Zero Suicide" Working Group and BBC Cornwall 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] 14.11.16** **[SIGNED BY CORONER]** Elizabeth Emma Cashyer