REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Department of Health, London 2. Chief Executive, Pennine Care NHS Foundation Trust
1	**CORONER** I am Ms L J Hashmi, Area Coroner for the Coroner area of Greater Manchester North.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 28th November 2016 I commenced an investigation into the death of **Dominic Adam Travis.**
4	**CIRCUMSTANCES OF DEATH** Dominic was an 18 year old man with a history of mental health problems. The formal medical diagnoses made were i) unspecified non-organic psychosis (ICD classification F29) & ii) Mental and Behavioural Disorders due to the use of Multiple Psychoactive Substances. At the time of his death, Dominic was also being investigated for Asperger's Syndrome/Autistic Spectrum Disorder ('ASD'). He had a past history of self-harm and was a regular user of cannabis and other substances then known as 'legal highs'. At the time of his death, Dominic was residing in supported living accommodation. The Staff who cared for him were not qualified in mental health care and during the course of their evidence they outlined the difficulties that they had encountered in accessing support for Dominic. Dominic was seen by the Access and Crisis Team on the 10th March 2015. He re-presented with paranoia and deterioration in his functional abilities and was reviewed by the Psychiatrist who commenced Olanzapine. On the 10th April 2015 Dominic presented to the emergency room ('ER') with psychotic signs and symptoms, agitation and aggression. Following assessment he was admitted as a voluntary patient to Southside Ward. On the 15th April, he was compulsorily detained under S.2 of the Mental Health Act ('MHA'). On a number of occasions, Dominic went AWOL but was brought back to the ward by police or paramedics each time. Dominic's condition remained unsettled. On the 27th April a Mental Health Tribunal upheld the decision to detain him compulsorily. On the 11th May, the Responsible Clinician made the decision to recommend continued detention under S.3 of the MHA. Dominic was assessed by a S.12 Dr and an approved mental health practitioner ('AMHP') who were initially unsure about continued detention. A multi-disciplinary team meeting took place and it was subsequently decided that Dominic did not meet the requirements for detention under S.3. The S.2 was allowed to lapse however Dominic agreed the stay on the ward until arrangements could be made for support in the community from the home treatment team ('HTT') and early intervention team ('EIT'). On the 13th May, Dominic returned to his supported living placement. On the 15th May, Dominic presented to the ER, via emergency ambulance, following deterioration

in his mental health status. He absconded but was returned a short while later whereupon he seen by the RAID Nurse Practitioner and subsequently discharged. The Nurse handed over to the HTT the following morning (16th May) who then visited Dominic at home. When eventually seen, he was described as having slept briefly, appearing unkempt and vacant. A review was carried out and medication administered.

On the 17th May the HTT visited again and were told by staff that they had maintained half to hourly checks of Dominic overnight. The HTT found Dominic to be unkempt, tremulous and sweaty. He was re-assessed and plans were made for further a HTT visit on the 19th. However, within 20-30 minutes of returning to the office the HTT received a call to say that Dominic's mental state had suffered an acute deterioration. Staff made provisional arrangements for an inpatient bed, pending assessment. They were of the view that Dominic required re-admission – voluntarily or compulsorily. Upon attendance, Dominic was floridly psychotic. He initially agreed to admission but then changed his mind. Whilst the Nurse made a call to the assessment team, the support time and recovery worker stayed with Dominic in the living area however when Dominic decided that he wanted to speak to his support worker in the office, he was allowed to make his way unsupervised. Almost immediately, an alarm sounded and it became apparent that Dominic had absconded via a fire exit. He was pursued but outran staff. A 999 call was made to police.

Some 20 minutes later, Dominic was found at the foot of a derelict mill close by and as having suffered catastrophic injuries.

He died in hospital on the 18th May 2015.

An inquest was held by me, sitting with a jury who concluded:

'...Misadventure. On 17th May the Deceased was found at Hartford Mill with fatal injuries. He was pronounced dead on the 18th May at Salford Royal Hospital.

The deceased had a history of mental health problems, exacerbated by the regular use of cannabis and so called 'legal highs'.

On 13th May he was released from detention under section 2 of the Mental Health Act in accordance with procedures. An appropriate care plan was put in place.

Following further psychotic episodes, mental health practitioners provided adequate ongoing care.

The deceased died as a result of misadventure, his decision making process being impaired by underlying psychosis and the ingestion of so-called 'legal highs'...'

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. **Department of Health:**

   Dominic was aged just 18 when admitted to an acute psychiatric ward that cared for adults aged 18-65.

   Given:

   i) the very stark differences between the mental health needs of younger adults and older adults,

   ii) an overall increase in the levels of vulnerability in such young people (by virtue of their age, condition, varying levels of maturity etc.),

   iii) that acute psychiatric ward environments often care for older adult patients with profound and enduring mental health problems (that are extremely frightening to the younger adult inpatient)

	& iv) the very different mental health requirements of young people, I am concerned that the needs of the latter are not being appropriately or adequately met, in the absence of specialist/specific inpatient provision. The vulnerability of young adults is clearly recognised and acknowledged in other areas such as young offenders under the age of 21 who are sentenced to YOI establishments rather than being sent to an adult prison, however no such recognition appears to exist in relation to young adults with mental health problems. **2. <u>Pennine Care NHS Foundation Trust:</u>** The internal investigation into the circumstances surrounding Dominic's death was inadequate as it lacked transparency and independence. The manager to whom the investigation was allocated subsequently delegated it to a Nurse who had been directly involved in Dominic's care - he was the HTT attending clinician on the 17th May when Dominic absconded in a floridly psychotic state. The incident was 'STEIS reported' but nothing further heard in this regard. Whilst the Trust's Medical Director has agreed to direct that a fresh investigation into the care that Dominic received be conducted (by an independent team), it became apparent during the course of the inquest that 'lower level' investigations are still being conducted by those directly involved in the patient's care due – it was said - to financial constraints. When potentially cost-neutral alternatives were discussed, the Trust confirmed that it was already considering such options but that it had no fixed plans or timescale for implementation. Given that time is of the essence in terms of 'lessons learned' from such investigations – even those purportedly described as 'low level' - any delays potentially go to a) patient safety and/or b) the prevention of future deaths.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 1st February 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 namely:- - The deceased's family - The Interested Persons - National Autistic Society - MIND - Young Minds - NHS England 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 from. 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: 7th December 2016 Signed: