REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. John Brouder, Chief Executive, North East London Foundation NHS Trust, Goodmayes Hospital, Barley Lane, Goodmayes, Ilford, Essex, IG3 8XJ**
1	**CORONER** I am Nadia Persaud, Senior Coroner for the Coroner area of East London
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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 27th January 2016 I commenced an investigation into the death of Peter Daniel Usher. The investigation concluded at the end of the Inquest on the 29th November 2016. The conclusion of the Inquest was a narrative conclusion: *Mr Usher took his own life. This was in part because the risk of his doing so was not fully and carefully assessed and appropriate precautions were not taken to prevent him doing so.*
4	**CIRCUMSTANCES OF THE DEATH** Mr Usher was a 39 year old gentleman. From January 2015 he had presented to his GP on a number of occasions complaining of symptoms of depression. In the very early hours of the 28th December 2015, Mr Usher sent a text to his brother which indicated possible suicidal intentions. At around 01:37 he was seen entering the grounds of the Bower Park Academy school. Police were called and found him with a deliberately sharpened twig held to his neck. Mr Usher also climbed up a tree in the presence of the police officers. They noted that a laptop and a belt were already in the tree. The belt was tied to a branch of the tree and in the presence of the officers Mr Usher tied the other end of the belt around his neck and threatened to jump. Mr Usher explained that he had just received some upsetting news about his relationship. He also admitted to drinking whiskey and taking cocaine that evening. The officers were able to talk Mr Usher down and he had to be tasered for his own safety. He was detained by the police under Section 136 of the Mental Health Act and taken into the Section 136 suite at Goodmayes Hospital. Mr Usher was taken to hospital at 02:56. The duty doctor and ACAT member were informed. The ACAT member set about checking records for prior psychiatric contact. Information was gathered from a previous attendance within another Trust under Section 136 in February 2015. A section 136 assessment took place by a junior doctor and the duty nursing officer. A decision was made to discharge Mr Usher from Section 136 at 04:50. He left the hospital at 05:00 on the 28th December 2015. From the evidence available at the Inquest it is likely that Mr Usher returned to the Bower Park Academy School on the 29th December 2015 and hung himself from a branch of a tree in the school grounds. His body was not located until the 21st January

	2016.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows. – 1. The assessing team did not carry out a detailed assessment of Mr Usher, to include not only a personal assessment but also to obtain relevant clinical information from both professional and non-professional sources. This would have included information from the family and GP. There was also relevant information available to the paramedics and police that was not elicited by the assessing team. 2. The Trust policy requires that the assessment should be carried out by the duty doctor and member of the Home Treatment Team. The policy also requires that the doctor must inform the on-call doctor of the arrival and discuss the outcome of the assessment with them. The Home Treatment Team member was not present during the course of the assessment. He was gathering relevant clinical information from a previous Section 136 attendance. The information appears to have been requested shortly after 03:00 and not received until around 04:47. This was partly due to safe haven procedures which had to be complied with, before a fax could be sent. The Home Treatment team member attended as the assessment was wrapping up. The on-call doctor was not informed of Mr Usher. 3. The Trust policy requires that an AMHP (Approved Mental Health Professional) be notified of the planned assessment. This also did not take place. 4. The police had received contact from family members whilst they were present at the hospital, confirming the concerns of family members due to the text received. This was not passed on to the hospital staff. It became apparent during the course of the Inquest that the police also had access to information which was relevant to the circumstances of the preceding events which would have been relevant to the mental state of the deceased. It would appear that inadequate questions were asked by the receiving hospital team in relation to the circumstances leading to admission. 5. The junior doctor gave evidence to confirm that he was the only doctor available for 11 wards and 200 patients. It would appear from information provided by the Trust, that the number of Section 136 assessments is increasing substantially and therefore there is a concern in relation to adequate medical staffing. 6. The evidence during the course of the Inquest and the evidence received from the independent psychiatrist raised a number of concerns in relation to the quality of the overall assessment and risk assessment carried out by the duty doctor. No issues relating to the medical input were identified in the Trust's own Root Cause Analysis. Further concern was raised during the course of the Inquest by the apparent lack of insight by the duty doctor and by the apparent inability to reflect on practice. 7. It is unclear from the evidence heard during the course of the Inquest whether there is any audit of clinical decision making during Section 136 assessments. 8. The Section 136 policy contains a 6 hour target for assessments to be completed. Section 136 itself, allows a period of up to 72 hours. It is unclear from the evidence as to whether the 6 hour limit places undue pressure upon staff to carry out assessments without gathering all of the available relevant evidence. 9. There were inefficiencies in practice which resulted in the member of the Home Treatment Team missing the 136 assessment. He had to wait for approximately 1 hour 45 minutes for clinical information to be provided. He had to go through Safe Haven procedures and to wait for a fax. An email to a secure email address may have avoided these delays.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 **27th January 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 [redacted] (representative for the family). I am also forwarding a copy to the Care Quality Commission, Borough Commander [redacted] (MPS) and to [redacted] (Director of Public Health). 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	**02/12/2016** **[SIGNED BY CORONER]**