Regulation 28: Prevention of Future Deaths report

Dominic Michael WHITE (died 10.11.16)

	THIS REPORT IS BEING SENT TO: **1. Mr Simon Pleydell** **Chief Executive** **Whittington Health NHS Trust** **Whittington Hospital** **Magdala Avenue** **London N19 5NF** **2. [redacted]** **Medical Director** **Barnet, Enfield & Haringey Mental Health NHS Trust (BEH)** **St Ann's Hospital** **St Ann's Road** **London N15 3TH** **3. Ms Wendy Wallace** **Chief Executive** **Camden & Islington NHS Foundation Trust (C&I)** **4th Floor, East Wing** **St Pancras Hospital** **4 St Pancras Way** **London NW1 0PE**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST**

	On 14 November 2016, one of my assistant coroners, William Dolman, commenced an investigation into the death of Dominic White aged 27 years. The investigation concluded at the end of the inquest on 19 May 2017. The jury made a narrative determination, a copy of which I attach.
4	**CIRCUMSTANCES OF THE DEATH** Dominic White had diagnoses of bipolar affective disorder and psychosis, but had been well for some time. However, in the few days before his death he very rapidly deteriorated. His parents took him to the emergency unit at the Whittington Hospital on Monday, 7 November; they called the crisis team at Canning Crescent for help on Tuesday, 8 November; and they returned to hospital with him via ambulance on Wednesday, 9 November. He spent most of 9 November in the emergency unit and was assessed as requiring detention under section 2 of the Mental Health Act, but before being conveyed to a mental health hospital with space for him, he walked out of the hospital emergency unit where he had been assessed. He was found the following day at an electricity substation, with injuries consistent with a fall from height. There was no evidence that any other person was involved in his death, but he lacked the necessary insight or intent to allow a determination of suicide to be a safe one.
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. Many issues were raised at inquest, but I was given information that the majority of these had been explored in advance of the hearing, and new ways of working had been found. The **MATTERS OF CONCERN** that remain, are as follows. 1. I heard that, following Mr White's death, the level of (mental health) observations of a patient at the Whittington Hospital Emergency Unit is now clearly documented. However, I am not sure that there is yet a robust protocol in place to ensure that all relevant personnel (Whittington EU doctors, nurses and security officers; also visiting independent s12 doctors, BEH and C&I staff) are aware of the level.

	My concern arises because sometimes, when anyone *can* look at a record, that nobody actually *does*. 2. The C&I approved mental health professional (AMHP) who gave Mr White permission to leave the hospital to go to McDonald's, *after* the decision had been made to detain him under section 2 of the Mental Health Act, acknowledged that she should have discussed this first with a colleague. However, she remained of the view at inquest that the decision itself had been the right one. Proof of this, she explained, was the fact that Mr White did return to the hospital from this visit. Allowing leave in these circumstances was a very unusual step I am concerned at the lack of recognition, even so long after the event, that allowing a person to leave the hospital in these circumstances: - was not necessarily the right one simply because the patient returned on this occasion (he left again within half an hour and never returned); and - had the potential to lull others into a false sense of security about his risk of absconding. The trust's root cause analysis action plan merely describes the need to have legally authorised permission to leave, without addressing any question of how to shape clinical decision making.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 by 24 July 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 following.

	• HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • Care Quality Commission for England • [redacted], approved mental health professional • [redacted], parents of Dominic White 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 24.05.17