Regulation 28: Prevention of Future Deaths report

Jonathan Anthony MEANEY (died 16.03.17)

	THIS REPORT IS BEING SENT TO: **1. 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** **2. [redacted]** **Medical Director** **Royal Free London NHS Trust** **Royal Free Hospital** **Pond Street** **London NW3 2QG**
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 17 March 2017, one of my assistant coroners, Richard Brittain, commenced an investigation into the death of Jonathan Anthony Meaney, aged 50 years. The investigation concluded at the end of the inquest on 15 August 2017. I made a narrative determination at inquest, a copy of which I now attach.

4	**CIRCUMSTANCES OF THE DEATH** Mr Meaney's medical cause of death was: 1a morphine and alcohol toxicity On Monday, 13 March 2017, he took an overdose and was taken to the emergency unit of the Royal Free Hospital, where he was assessed in the early hours of the following morning, Tuesday, 14 March, by a junior doctor from the Camden and Islington NHS Foundation Trust liaison psychiatry team. She decided that he needed to be admitted to hospital for inpatient treatment, and he agreed. However, no bed was found for him, and on Wednesday, 15 March, Mr Meaney told the assessing mental health nurse that he would prefer to leave and was discharged. He went home and the following day he took his own life.
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. Mr Meaney waited in the emergency unit for 40 hours and so it was unsurprising that he was then keen to go home. A mental health nurse from the C&I psychiatry liaison team called the bed manager on the morning of Tuesday, 14 March, and then saw Mr Meaney briefly to explain that no bed was available. The same nurse called the bed manager again the following morning, Wednesday, 15 March, and then saw Mr Meaney once again with no news about admission. It was at that point that Mr Meaney expressed a wish to leave. There seemed no urgency about the need for a bed for such a seriously ill man. 2. When the mental nurse assessed Mr Meaney before discharge on Wednesday, 15 March, he did not question Mr Meaney's assertion that he had not intended to take an overdose two days before. This was despite the fact that Mr Meaney had told the assessing doctor that he had been trying to kill himself and he had written notes of intent.

	3. The mental health nurse assessed Mr Meaney as rational and having good insight, despite the fact that Mr Meaney once again (as he had done repeatedly for many months) raised a physical problem for which no organic cause had been found. In court, the mental health nurse told me that he knew that Mr Meaney's illness was mental rather than physical. 4. The mental health nurse did not consult any other member of the team before clearing Mr Meaney as fit for discharge from a mental health point of view. (The assessing doctor gave evidence that, if Mr Meaney had not agreed to admission to hospital when she saw him, she would have sought an assessment under the Mental Health Act with a view to detaining Mr Meaney for treatment.) 5. The mental health nurse who saw Mr Meaney decided to refer Mr Meaney to his general practitioner for counselling, though Mr Meaney had already said that he had not found the crisis team helpful. Then having made that decision, I heard that there was no evidence that the mental health nurse did go on to make the referral. He told me that all he would do in such a situation would be to send the GP a discharge summary, never with a short accompanying note of request.
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 23 October 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], mother of Jonathan Meaney • [redacted], partner of Jonathan Meaney

	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** 24.08.17