REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Medical Officer for Wales**
1	**CORONER** I am Christopher John Woolley, Assistant Coroner, for the Coroner area of South Wales Central
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** In June 2015 I commenced an investigation into the death of Khuong Lam. The investigation concluded at the end of the inquest where I sat with a jury on 14th July 2017.The medical cause of death was: 1.a A sudden collapse in a 42 year old man with schizophrenia and recent behavioural abnormality taking Quetiapine, after a prolonged struggle and pressure to the neck. The jury returned a narrative conclusion as follows:
4	**CIRCUMSTANCES OF THE DEATH** Khuong Lam had had a long history of schizophrenia, having first undergone treatment in January 2004. He had periods of stability but also periods of relapse, and in 2007 he was admitted for 8 weeks as an inpatient at Whitchurch hospital. In June 2015 his condition worsened and he was admitted to the Crisis Assessment Ward at Whitchurch Hospital on 15th June 2015 under Section 2 of the Mental Health Act and then transferred to the Psychiatric Intensive Care Ward (PICU) on 23rd June 2015. The Responsible Clinician (RC) was not informed of the transfer and the Section 17 leave form was not revoked or reviewed on transfer to the PICU by the RC. He was granted Section 17 leave on the 19th June and enjoyed such leave on at least two occasions prior to the 25th June outside the hospital grounds. On 25th June 2015 he was taken on a further period of Section 17 leave and absconded. The hospital were informed by the carer of the absconsion and the police were involved to assist in the search. Khuong Lam was traced to Asda café in Coryton. Police officers attended at the café and allowed him to finish his meal before escorting him out of the café via the fire door. He then absconded from the police officers. A search was undertaken but he was not found. At around 2.30pm Khuong Lam saw a [redacted] on the path and he began to say threats to him and took off his belt with which he hit [redacted]. There was a struggle in which Khuong Lam put the belt around [redacted] neck, and then [redacted] managed to get it off his own neck and put it around the neck of Khuong Lam, intending by that action to counter an imminent threat of harm to himself. Khuong Lam then died. The pathologist gave as his opinion at Khuong Lam died from a combination of factors, any one of which might have been fatal. He also said that the lack of petechiae showed that the belt had only been around his neck for under 15 seconds and in most people this would have just resulted in a sore throat. The police later arrested [redacted] but no further action was taken against him. .

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. –

For the Chief Medical Officer, Wales

(1) The issue of Section 17 leave is covered in the Guidance issued in 2016. There is no section in this guidance covering the issue of review or revocation of Section 17 leave on transfer to another ward or to the PICU. It is the concern of the coroner that such guidance should be given across Wales in the next edition of the guidance.

(2) The inquest heard evidence that two escorts can provide a deterrent effect against absconsion, and are better able to deal with absconsions. Cardiff and Vale Health Board have now concluded a two month study of the efficacy of having two escorts to a patient on Section 17 leave and the lessons of this study should be applied across Wales.

(3) the RC told the inquest that if he had been made aware of Khuong Lam's transfer to PICU he could have reviewed him and decided whether Section 17 leave was still appropriate. The Coroner is concerned that the good practice now adopted by Cardiff Health Board should be replicated across Wales i.e. that the RC be informed of any transfer between wards; that Section 17 leave is reviewed on a transfer (and especially to PICU); and to consider further the number of escorts required for any Section 17 leave.

(4) The review of this incident is being presented to an All Wales forum on mental health (Service Collaboration Group) on 11th October 2017 and it may be that the Chief Medical Officer can further any resolutions that may come out of this meeting. The Chief Medical Officer may wish to ensure that any lessons are discussed or disseminated in any other appropriate Mental Health forum. The Coroner accepts that it is for the Chief Medical officer to decide the best way to do this.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe that the Chief Medical Officer for Wales has 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 18th September 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:

1. (for Khoung Lam's family)
2. The Chief Executive, Cardiff and Vale Health Board
3. The Chief Constable, South Wales Police.
4. The Health and Safety Inspectorate of Wales
5. The Minister of Health, Welsh Assembly Government

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	**24th July 2017** **C J Woolley** **Assistant Coroner, South Wales Central**