	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **1. Mr Ben Travis, Chief Executive, Oxleas Mental Health Trust, Pinewood House, Pinewood Place, Dartford, Kent DA2 7WG**
1	CORONER I am Andrew Harris, Senior Coroner, London Inner South jurisdiction
2	CORONER'S LEGAL POWERS I make this report under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	INQUEST I opened an inquest into the death of **Mr Rastislav Petrisko, who died on 16.04.17 in University Hospital Lewisham;(Case Ref: 01106-17 JB).** It was concluded on 28th February 2018. The medical cause of death was: 1a Use of morphine and cocaine, exacerbated by alcohol intake The conclusion stated that he died from an overdose of drugs but the jury could not be sure beyond all reasonable doubt that he intended for the act to end his life.
4	CIRCUMSTANCES OF THE DEATH He was a man with a personality disorder, homeless and isolated from family abroad, with a history of drug and alcohol misuse and chronic negative thoughts of suicide. He only injected heroin as part of his plan to kill himself. He had fifteen in-patient admissions to a mental health ward between May 2015 and April 2017, many were after genuine suicide attempts. He was admitted on 1st April under section 2 of Mental Health Act, having tried to kill himself with drugs and was angry to have been resuscitated. On 15th April, he was verbally abusive and agitated after homophobic comments of another patient, but calmed before being given leave which he used to return to a car park which was used by drug users and from which he had been admitted twice before. There he again took an overdose of drugs. He was attended by emergency services at 22.32, after being called by a passer-by and was still alive but was not able to be resuscitated. The jury found that he died in part due to his on-going lack of engagement with statutory services. His low risk assessment before given leave on 15th April seemed unsuitable and contributed to the delay of the ward in notifying the police, when

	Ratislav Petrisko failed to return to the ward at 19.25. The jury recorded that the decision to allow unescorted leave seemed inappropriate and the risk to himself was not recognised.
5	**CORONER'S CONCERNS** During the course of the inquest, the evidence revealed a matter giving rise to concern that in my opinion means that there is still a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTER OF CONCERN** is as follows. - The responsible clinician (RC) assessed the patient as low risk on granting an hour's unescorted leave in the local area from 13th. He said that he was not mentally unstable, which would trigger an escort. He was no longer expressing suicidal thoughts. The RC did not consider that Mr Petrisko was an immediate risk to himself, although the past medical history established a higher long term risk. He had already taken leave several times without self-harming (although unknown to the doctor he had returned drunk on 8th whilst in another unit). Although there was reference to recent or pending drug testing there was no record of the result of any drug screening on return from leave in this admission. A nurse indicated that being high risk made no difference to the likelihood of drug screening and the RC indicated that he may still be given leave if he was high risk. However a mental health nurse on the ward said that he was given leave as he was low risk. The risk assessments were guided by the statutory guidance of the Mental Health Act and were not subject to further local guidance. In retrospect the RC did not change his risk assessment. A missing persons form was completed by the ward. His risk was described as concern he would take large amount of drugs and alcohol, which would affect his mental state and that it was not out of character. In answer to the question whether he was likely to commit suicide, was written: "Was admitted with overdose cocaine and medication with suicidal intent". The police were called at 21.56 and attended at 23.30, by which time emergency services were already in attendance to him in the car park, following a 999 call. As he was low risk the local policy on handling patients who had absconded at the time indicated that he could be given a period of grace before the police were notified, if he did not return at the allotted time. This was given as he had a history of being late back from leave. The ward notified the police 1 hour 49 minutes after he was due back, a period of time acknowledged to be too long. The policy in place made clear that a high risk patient should be reported immediately. The revised Trust policy continues that requirement, removes the period of grace but leaves it to the discretion of the clinicians when to call the policy, if the patient is deemed not to be high risk.

	The DI from the Metropolitan Police Service indicated on reviewing the case, that he would be classed as medium risk, not low risk. High risk is an immediate risk to life, when a DI is deployed immediately to investigate and search. Medium Risk is that the risk to life is not immediate, but is a concern. An investigation and search is begun within the hour. Low risk is where there are no immediate concerns. The investigation may not begin straight away but take a few days. She further said that an immediate action would be to identify the places from which he had been admitted before. The medical records indicated that of the last three admissions he had been brought in from the Calderwood Street Car Park on two occasions (13.12.16 and 05.01.17). That was the site where he took the final fatal overdose. Thus if the police had been rung immediately, and assuming they took no action for the whole of the first hour, they would have had at least 49 minutes to find him in this site, which on the facts of the present case would enable an inference to be drawn that his life would have been saved. Thus the risk assessment by the police would seem to enable some deaths to be prevented, which would not necessarily on application of the assessment of the responsible physician, as immediate reporting only occurs if the patient is high risk. It is of concern that there are two different methods of assessing the risk when a vulnerable patient is granted leave, both in operation, one with greater potential of saving his life than the other.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths. I believe that the NHS Trust has the power to take such action. I recognize that to do so may involve other organizations. I am therefore copying this to the Metropolitan Police Service and Royal College of Psychiatrists and attaching Oxleas Procedure for missing /absconding patients who are absent without leave, version 3.2.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by Monday April 30th, 2018. 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. If you require any further information or assistance about the case, please contact the case officer, [redacted]

8	**COPIES and PUBLICATION** I have sent a copy of my report to the following Interested Person: [redacted] Mother I am also sending this report to the following, who may have an interest: [redacted] Metropolitan Police Service Royal College of Psychiatrists 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	**[DATE]** 06-03-18 **[SIGNED BY CORONER]**