## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

## Thomas Edward Curtin

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. Mr Joseph McEvoy, Regional Director of Mental Health and Learning Disabilities, Specialist Commissioning, NHS England South** |
| 1 | **CORONER**<br><br>I am Dr E Emma Carlyon, Senior Coroner for the coroner area of Cornwall and the Isles of Scilly |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>Mr Thomas Edward Curtin died on 20th August 2016 at the Royal Cornwall Hospital, Truro. He was being held under S3 MHA 1983 at Longreach Hospital, Redruth on an Acute Mental Health Ward. An Inquest was opened on 9th September 2016 and a full inquest hearing with a jury was held on 22, 23 and 26, 27th February 2018 at Truro Municipal Building, Truro where the cause of death was determined as 1a) heroin intoxication and the conclusion was found to be a Drug Related Death. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Thomas Curtin was detained under S3 Mental Health Act 1983 at Longreach Hospital, Redruth on an acute mental health ward and was awaiting placement on a locked rehabilitation facility. On 19th August 2016, he was granted S17 pre-arranged escorted leave to purchase a Game Station from a shop in Camborne. The S17 leave was for one hour with conditions on it to not gamble, or take drugs or alcohol. His money was held by the escort. At around 1.00 pm, Mr Curtin was taken by hospital car to the shop and the escort purchased the game station. A particular game was not in stock and due to the lack of time the escort advised that the game would have to be purchased the next day. Mr Curtin absconded from the shop with the game station and against advice from the escort to return with him to the hospital, Mr Curtin ran off. The hospital and police were informed that he was missing in line with hospital policy at 14.38 pm. Mr Curtin attended 21 Adelaide Street, Penzance to visit its occupants at around 8.00 pm. He visited the chip shop with a male from the house and they returned to the property by taxi at around 9.15 pm. He told the male he had taken heroin and he was seen to be sleeping at around 22.30 pm. The other male went out and returned around 12.30 pm and later found him not breathing. At just before 02.53 am he called for an ambulance and started resuscitation and the paramedic arrived and continued advanced resuscitation and his pulse was regained at 03.20 am. He was transferred to the Royal Cornwall Hospital, Treliske, Truro but despite medical support he was recognized dead at 07.30 am on 20th August 2016 from heroin intoxication. Mr Curtin was diagnosed with schizophrenia with ADHD with harmful misuse of alcohol and drugs and psychoactive substances. He was not known to use heroin. It was not known when or when or how or with what intention that he took the heroin. |

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| | The Expert Psychiatrist noted that:<br><br>On reviewing the notes it was clear that Mr Curtin had been identified as being at high risk of absconding and a risk to himself and others and for this reason a locked rehabilitation placement was being sought.<br><br>The view of the treating Psychiatrist was that the benefit of leave outweighed the risk of the frustration of no leave and minimized the distress of being on the ward especially given his restlessness from ADHD and his variable presentation. He also accepted that the leave was to build up a therapeutic relationship and to educate Mr Curtin not to gamble, drink or misuse drugs while in the community. His psychotic symptoms appeared to have been well controlled and the treating team identified that a longer period of rehabilitation in a locked rehabilitation ward was required to avoid relapse. He was awaiting such placement and the process had been started to identify a facility. He considered that it was a challenge to manage Mr Curtin while awaiting the placement and it was a balance between holding him on the acute ward where he was known well or a secure placement which [redacted] did not consider appropriate. He considered the acute ward was the appropriate place to hold Mr Curtin pending his placement with a transfer to Harvest Ward if his behavior escalated and there was a need to intervene. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>At the hearing witnesses from the treating Mental Health Trust advised the court that Mr Curtin was identified as requiring a placement on a locked rehabilitation ward to treat the chronic nature of his illness namely of schizophrenia, with ADHD with harmful misuse of alcohol and drugs and psychoactive substances and to prevent relapse. The majority of such facilities are provided by the private sector. Evidence at inquest revealed that public entities of low and medium security facilities were subject to a National NHS England framework concerning the timing of their response to referrals for specialist units. The evidence at inquest was that private providers of "Locked Rehabilitation Units" were not subject to such a National NHS England framework. This may lead to the risk of future deaths as patients are left on a ward which is inappropriate for their needs while awaiting the private provider's response to a referral. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation; have the power to take such action.<br><br>To take action to reduce the potential for delay in placement of patients due to lack of National framework for response to referrals from private providers. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by the 9th May 2018. I, the coroner, may extend the period.<br><br>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. |

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| 8 | **COPIES and PUBLICATION**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Coodes Solicitors for the family, Adult Safeguarding Board, Devon and Cornwall Police and Cornwall Partnership Trust. I have also sent it to Kernow Commissioning Group who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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]**<br><br>**14.03.2018** | **[SIGNED BY CORONER]**<br><br>Elizabeth Emma Carlyon |