REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Mr Neil Thwaite, Chief Executive, Greater Manchester Mental Health NHS Foundation Trust, Bury New Road, Prestwich, M25 3BL **2.** [redacted] Manager, Mental Health Liaison Team, Manchester Royal Infirmary, Oxford Road, Manchester, M13 9WL
1	**CORONER** I am Timothy W Brennand, Assistant Coroner, for the Coroner Area of Manchester West
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** On the 7th February 2018 I commenced and Investigation into the death of Karl Olof Jamil Joulam Engelmark Cassimjee, aged 30 years, born on 24th February 1987. In Investigation concluded at the end of the Inquest on the 17th October 2018. The medical cause of death was: 1a. Hypothermia The conclusion of the Inquest was a short form conclusion of "accidental death".
4	**CIRCUMSTANCES OF THE DEATH** 1. The deceased had a history of presumed paranoid schizophrenia with psychotic episodes that had been treated and managed in his home country in Sweden conservatively. 2. In August 2017, the deceased arrived in the United Kingdom seeking employment. 3. He suffered a mental health relapse and on the 16th August 2017 was referred to the Chester Community Mental Team for treatment and care that was to involve inpatient admission on the Lakefield Ward at Clatterbridge Hospital, Cheshire. Following discharge on the 21st September 2017, the deceased moved to Manchester. 4. On the 31st January 2018, the deceased was detained by British

Transport Police at Piccadilly Railway Station under the provisions of Section 136 of the Mental Health Act 1983 and taken to Manchester Royal Infirmary. He was assessed by a Psychiatry Registrar and diagnosed as requiring further engagement with the Mental Health Home Treatment Team (hereafter MHHTT) and police returned him to his residence at [redacted]

5. Upon being delivered to his home address, the deceased became agitated and distressed. British Transport Police Officers assumed the deceased, being no worse than his observed condition prior to his assessment at the Manchester Royal Infirmary, took the decision to leave the deceased at the address in the hope that he would calm down and settle. No other check or enquiry was made with occupiers of the address. The address in fact, appeared to be empty.

6. A MHHTT practitioner attempted contact by telephone which took place on the 1st February 2018 which resulted in no response or reply.

7. The deceased was not at his home address when the MHHTT practitioners visited on the 2nd, 3rd, 4th & 5th February 2018.

8. The MHHTT reported the deceased as missing on the 3rd February 2018.

9. A Greater Manchester Police investigation established that the deceased was last seen alive on the 2nd February 2018 at the Hilton Hotel, Manchester whilst acting in an irrational and bizarre manner.

10. On the 5th February 2018 his body was discovered in a collapsed, unresponsive condition in a semi-remote temporary industrial site where the land had been churned up by heavy vehicles adjacent to open fields near Unit 2, Bridgewater Avenue, Over Hulton, Bolton. Paramedics pronounced him dead at the scene. Whilst there was no evidence to explain where the deceased had been between the 2nd and 5th February 2018, the evidence demonstrated that the deceased was psychotic, delusional and had become lost in an area he was not familiar with and succumbed to hypothermia as a consequence of the prevailing freezing temperatures and collapsed in muddy terrain and died.

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:

Brief circumstances of matters of concern

1. During the Inquest, evidence was heard that:

a. A Mental Health Act assessment had been completed without a collateral history being obtained (including Clatterbridge Hospital);

b. The assessment completed by the Specialist Registrar was entered on the "Amigos" system in the incorrect format with no supporting entry form from the second section 12 approved Mental Health Practitioner;

c. The assessment, as recorded by the Registrar was accepted to be sub-optimal;

d. The record of the risk assessment has no clear formulation of risk and no evidence of collaborative safety planning with the deceased (that is to say, clear evidence that the deceased received advice as to what measures he could take in the event of a deterioration in his condition from discharge to being seen by the Mental Health Home Treatment Team.

e. It is unclear from patient records as to what information the deceased and/or the British Transport Police (who were tasked with the responsibility of physically taking the deceased back to his home) about contact with the MHHT or what action to be taken in the event of a deterioration in the interim;

f. A Mental Health Nurse had recorded a substantial and detailed history given to her by the deceased setting out the full extent of his florid delusional paranoid beliefs that do not seem to have been fully, adequately or properly evaluated by the Speciality Registrar, to the extent that the nurse expressed extreme surprise that the Registrar had not seen fit to recommend Mental Health Act detention – there being no means within the operational procedures in place for the nurses concerns to be taken into account;

2. Whilst the Greater Manchester Mental Health Trust had conducted a comprehensive Incident Review report that correctly identified:

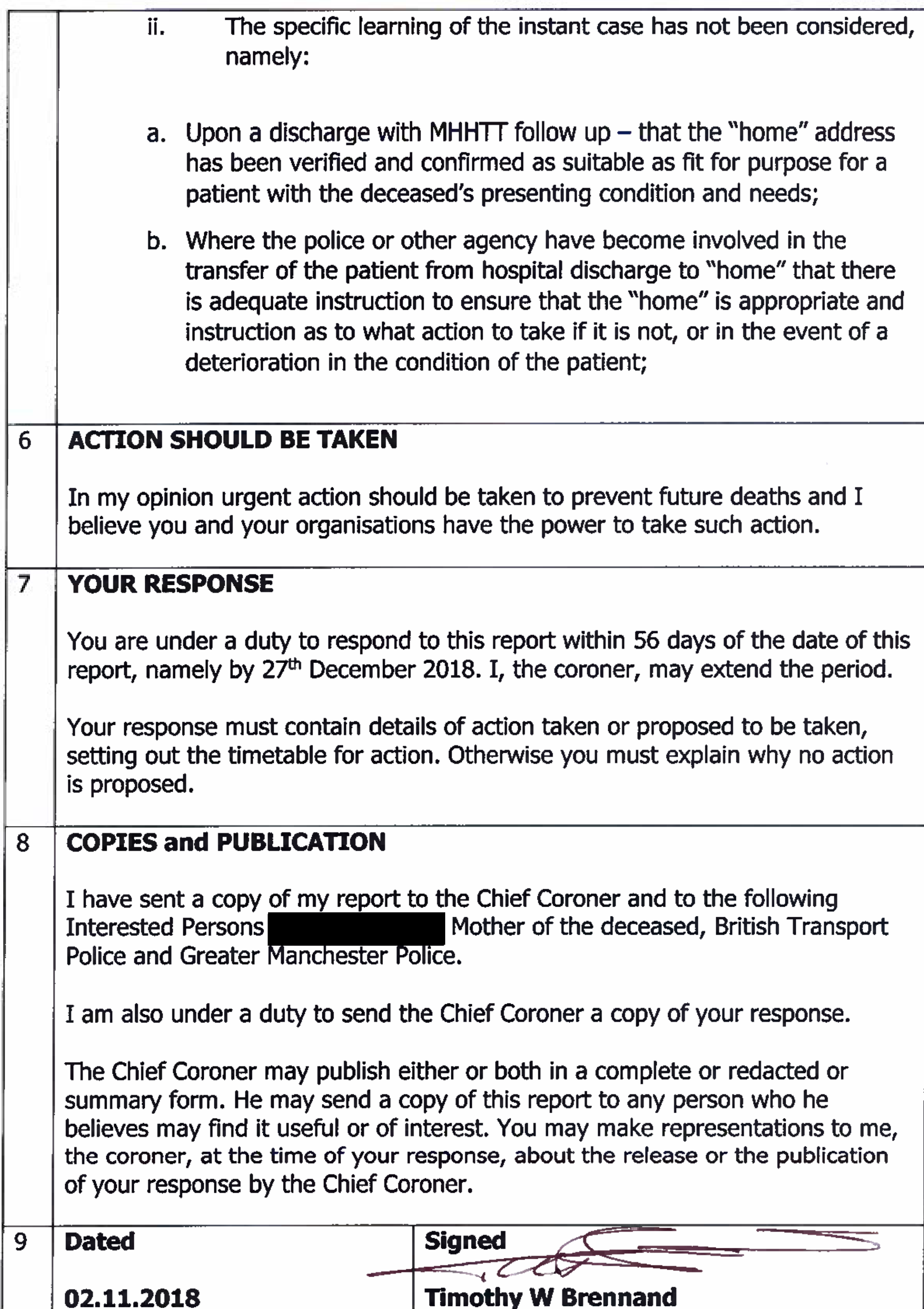
   a. The need for the Community Mental Health Team operational procedure to be revised;

   b. The need for a revised Multi Disciplinary Team agenda approach to attach and apply in such case;

   c. A reminder to mental health liaison practitioners to improve record keeping and adherence to existing systems and protocols, including involving all such practitioners in the "decision making" process;

   However, the evidence received at Inquest confirmed that:

   i. To date, the operational systems identified as in need of revision and review have not been put in place or actioned;



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<tr><td></td><td colspan="2">ii. The specific learning of the instant case has not been considered, namely:

a. Upon a discharge with MHHTT follow up – that the "home" address has been verified and confirmed as suitable as fit for purpose for a patient with the deceased's presenting condition and needs;

b. Where the police or other agency have become involved in the transfer of the patient from hospital discharge to "home" that there is adequate instruction to ensure that the "home" is appropriate and instruction as to what action to take if it is not, or in the event of a deterioration in the condition of the patient;</td></tr>
<tr><td>6</td><td colspan="2">ACTION SHOULD BE TAKEN

In my opinion urgent action should be taken to prevent future deaths and I believe you and your organisations have the power to take such action.</td></tr>
<tr><td>7</td><td colspan="2">YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 27th December 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.</td></tr>
<tr><td>8</td><td colspan="2">COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] Mother of the deceased, British Transport Police and Greater Manchester Police.

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.</td></tr>
<tr><td>9</td><td>Dated

02.11.2018</td><td>Signed

Timothy W Brennand</td></tr>
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