	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Chief Executive, Midlands Partnership NHS Foundation Trust.
1	**CORONER** I am Mr James Bennett, HM Area Coroner for Birmingham and Solihull.
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 07/01/2019 I commenced an investigation into the death of Andrew Peter Wells. The investigation concluded at the end of an inquest on 13/09/2019. The conclusion of the inquest was that Andrew's death was due to suicide. The primary cause was his severe anxiety and depression. However, Andrew had: (1) On 14 December threatened to end his life. (2) On 16 December placed a cord around his neck. (3) On 23 December having left the unit, charged and head-butted a car, and threatened to jump of a bridge. (4) On 25 December in the unit, placed a cord around his neck. (5) On 25 December having left the unit, attached a ligature to a branch which snapped. (6) On 27 December demanded to be let out of the unit and threatened to kill himself. On 27 December it was predictable that Andrew would attempt to leave the unit and take his own life. The only Dr to assess Andrew, after he returned to the unit on 25 December, was a junior on-call Dr who incorrectly understood Andrew would be assessed on the morning of 27 December by the consultant psychiatrist. Upon returning to the unit on 25 December 2018 Andrew: (1) was not sectioned when he should have been. (2) was not put on 1:1 or intermittent observation levels when he should have been. Having demanded to be let out, and threatened to kill himself, on 27 December 2018 Andrew: (1) was not sectioned when he should have been. (2) was not put on 1:1 or intermittent observation levels when he should have been. Had Andrew been sectioned he would have received a more complete and adequate assessment of his mental health needs and risks. Had Andrew been on 1:1 or intermittent observation levels, the 'relational-ship' security would have increased the opportunity for staff to recognise a pending escape attempt and take preventive measures. It is *possible* that (1) a section and (2) increased observations would have prevented Andrew's death. It cannot be said that (1) and (2) would have *probably* prevented his death, because (a) sectioned patients had access to, and were encouraged to use, the garden, (b) staff did in fact try and persuade Andrew not to escape when he was vacillating, and (c) due to the risk of harm to staff and the patient, staff were trained not to restrain a patient in the act of escaping.
4	**CIRCUMSTANCES OF THE DEATH** Andrew had a long, but intermittent, history of anxiety and depression. This was successfully managed by his GP prescribing medication and cognitive behavioural therapy. He was not considered to be at risk of suicide. On 10 December 2018, Andrew visited his GP reporting he would be better off dead and asked for anti-depressant medication. A further consultation was arranged for 2 weeks by which time it was expected

the medication would have started to have effect.

On 13 December 2018, Andrew visited his GP for a sick-note reporting he had had a panic attack at work. The 2 week consultation was retained.

On 14 December 2018, Andrew told his wife he had thought about killing himself and had considered lying on the sofa with a bag over his head. Andrew requested a telephone consultation with his GP who referred him to the mental health crisis team. The crisis team telephoned Andrew and arranged an appointment on 17 December 2018.

During the early hours on 16 December 2018, Andrew tied a dressing gown cord around his neck, but bumped the bed waking his wife, consistent with him wanting to be interrupted. His wife intervened and during a struggle Andrew was talking about wanting to die.

The crisis team quickly assessed Andrew at home. Later that day, he was voluntary admitted to the George Bryan Centre, a general acute psychiatric unit. Andrew requested that potential ligature items be removed from his room. Typical with all new patients, Andrew was commenced on intermittent (every 5-15 minutes) observations. His suicidal ideation was recorded in his RIO notes. Andrew was assigned a Named Nurse. She was working night shifts and only had one 1:1 session with Andrew. However, other nurses and support workers engaged with him.

On 17 December 2018, Andrew was assessed by the consultant psychiatrist. It was agreed he would remain on anti-depressant medication and would be referred to the community mental health team in due course. It was anticipated he would remain at the unit until after Christmas.

On 18 December 2018, Andrew's observation levels were changed to general (hourly) observations.

At about 16.00hrs on 23 December 2018, during a visit from his wife, Andrew unexpectedly shouted he was 'done' and ran out of the unit. He charged and head-butted a stationary car and threatened to jump off a bridge. Staff persuaded Andrew to return to the unit. A junior on-call Dr detained Andrew under section5(2) of the Mental Health Act 1983. His general (hourly) observation levels were maintained. The junior Dr expected Andrew to be reviewed the following day by the consultant psychiatrist.

At about 12.00hrs on 24 December 2018, Andrew was assessed by the consultant psychiatrist. He was now considered stable and the section5(2) was removed. This was recorded in his RIO notes. His general (hourly) observation levels were maintained.

On 25 December 2018, Andrew tied a cord from his jacket around his neck in his bedroom. At about 11.00hrs he told a support worker who told a nurse. A Dr was not asked to assess Andrew. By 12.30hrs Andrew had left the ward without shoes or a coat. He smoked cannabis and tied a cord from his hoodie around a tree branch, but the branch broke. He telephoned his wife and reported what he had done. The police were alerted and commenced a search. At about 17.00hrs Andrew of his own accord returned to the unit. During the next three shifts no Dr was asked to assess Andrew. His observation levels were maintained as general (hourly) observations.

Four shifts later, on 26 December 2018, a nurse asked the on-call Dr to assess Andrew as a consequence of the events the previous day. At about 17.36hrs a junior Dr assessed Andrew. She was provided with a verbal handover but did not look at the RIO notes. She incorrectly understood that Andrew was still subject to section5(2) detention. She incorrectly recorded in her RIO note that Andrew was subject to section5(2) detention. She incorrectly understood Andrew would be assessed the next day by the consultant psychiatrist during a routine ward round. His observation levels were maintained as general (hourly) observations. The nurse, who knew Andrew was not on section5(2) detention, did not appreciate the Dr's error or notice she had incorrectly recorded in her RIO note that he was subject to section5(2) detention.

Generally, Andrew had no physical health problems but would regularly express concerns about his own mortality due to serious illness.

On 27 December 2018, at about 7.48hrs, Andrew was in his boxer shorts in a communal area and told a support worker he felt unwell and that he had blood poisoning due to not wearing shoes when he left the unit on 25 December. He was provided with reassurance. The Nurse in Charge was informed. A Dr was not asked to assess Andrew.

At about 10.00hrs Andrew's wife telephoned the unit asking to speak to the consultant psychiatrist as

	she was concerned about her husband's bizarre behaviour. (His wife and daughters had on multiple occasions during his admission reported their concerns to staff). The Dr was unaware of the request and did not call Andrew's wife. At about 10.30hrs Andrew attended the ward office demanding to be let out. He was screaming he was going to kill himself or someone else. He said he felt trapped. He was calmed by the Ward Manager and encouraged to have his breakfast and a shower. A Dr was not asked to assess Andrew. The Ward Manager had a brief discussion with the consultant psychiatrist. They maintained Andrew's informal status. Formally his observation levels were maintained as general (hourly) observations, informally staff were aware of the need to maintain regular observations and engaged with Andrew. Andrew was outside in an internal unit garden. There was a high anti-climb boundary fence. But consistent with the unit being a general acute unit, the garden was not designed in a way to prevent a determined patient from escaping. At about 12.20hrs Andrew was seen on the roof, having climbed up a drain pipe which was not boxed in by anti-climb fence. Staff were alerted and a nurse walked out of the unit into the garden. Andrew was now back in the garden, but upon seeing the nurse, he quickly climbed back onto the roof, walking across and down off the roof, sitting on fence panel behind the anti-climb fence. The Ward Manager and a nurse in the garden spent several minutes trying to persuade Andrew to return to the unit. Members of staff were sent out of the unit to Andrew's position before he climbed off the fence and left the area. Members of staff commenced a search in a car, and the police were alerted and also commenced a search. At about 13.13hrs a member of the public alerted the police to a man - later confirmed as Andrew - hanging from a tree in a secluded location accessible from a canal path near Bonehill Road canal bridge, Tamworth. Police officers attended promptly but struggled with the thickness of the rope ligature and height of the branch. Andrew was cut down at about 13.30hrs. He was in cardiac arrest. Police and paramedics commenced CPR and spontaneous circulation was achieved at 13.55hrs. He was taken to hospital and a CT-scan revealed a severe brain injury due to it being starved of oxygen during the cardiac arrest. Andrew remained in a critical condition and required advanced life support. He died at 18.55hrs on 31 December 2018 at Birmingham Heartlands Hospital. According to his treating clinician the medical cause of death was determined to be: 1a Hypoxic Brain Injury, 1b Hanging.
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. The Trust's Internal Root Cause Analysis investigation reviewed the decision making of the clinicians including the role of the treating consultant psychiatrist, the unit's Responsible Clinician. However, on one on the investigation team was a psychiatrist, or of a similar status to the Responsible Clinician. The RCA report agreed with the Responsible Clinician that the decision making around Mr Wells' informal status and observation levels was appropriate. The draft RCA report went through a governance exercise, and a member happened to be a consultant psychiatrist, but this did not involve scrutiny of the evidence. I agreed with the evidence from an independent expert consultant psychiatrist that the decision making of the clinicians, including the Responsible Clinician, was not appropriate. Therefore, my on-going concern is that the Trust's RCA process is not robust or effective enough to learn lessons from serious incidents. 2. The expert witness also stated the Mental Health Act was not applied appropriately. Namely, whilst Mr Wells was technically an informal patient, the clinicians recognised that he would be detained if he tried to leave i.e. he was 'de-facto' detained without the additional resources and safeguards applicable to a detained patient being put in place. The expert witness said 'de-facto' detention was contrary to the Code of Practice to the Mental Health Act and Mr Wells should have been detained. Therefore, my on-going concern is that the Trust's clinicians are not applying the Mental Health Act appropriately.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 15 January 2020. 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 family. I have also sent it to NHS England who may find it useful or of interest. 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	19/11/2019 Signature  Mr James Bennett, HM Area Coroner, Birmingham and Solihull