Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

Rt Hon Nadine Dorries MP
Minister for Patient Safety, Suicide Prevention and Mental Health
Department of Health and Social Care
39 Victoria Street
London
SW1H 0EU

The Chief Executive Norfolk and Suffolk NHS Foundation Trust,
Trust Headquarters
Hellesdon Hospital
Drayton High Road
Norwich
NR6 5BE.

1 CORONER

I am Nigel Parsley, Senior Coroner, for the coroner area of Suffolk.

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 10th September 2019 I commenced an investigation into the tragic death of Joshua SAHOTA

The investigation concluded at the end of the inquest on 8th September 2021. The jury conclusion of the inquest was that:-

The jury recognise that Josh was an intelligent, polite, reserved well-loved and supported young man by his family and friends.

Joshua Sahota died as a result of Asphyxia, by deliberately placing a plastic bag over his head and use of a bed sheet around his neck.

We the Jury were unable to determine Josh's state of mind at the time of his death.

The below contributing factors led to Josh's death.
- Insufficient staffing
- Insufficient Observations and 1 to 1's
- Inadequate formal documentation
- No Psychologist available.
- Unclear restricted items policy.

The medical cause of death was confirmed as:

1a Asphyxia

2 Psychosis

4 CIRCUMSTANCES OF THE DEATH

Joshua was a 25-year-old man who on the 2nd August 2019 intentionally drove his car off a bridge on the A11 landing on the A14 dual-carriageway beneath.

This incident caused Joshua chest and pelvis injuries and as a result he was admitted to the Addenbrookes Hospital in Cambridge on the same day.

Whilst Joshua had been an inpatient at Addenbrookes he had been seen by a psychiatrist and deemed to be at a continuing high risk of self-harm.

As such, when Joshua was deemed medically fit, his discharge was directly to a psychiatric bed on Southgate Ward, Wedgewood House, Bury St Edmunds, in Suffolk.

Joshua's admission took place on the 9th August 2019 as an informal patient.

As Joshua was admitted directly from Addenbrookes he was in a hospital gown only, as his clothes had been cut from him when he arrived at Addenbrookes hospital from the scene of the road collision.

Joshua's family were asked to take fresh clothes to Southgate ward, which they did in a plastic carrier bag. The bag was emptied by a member of staff, the contents were searched, re-packed and then taken to Josh's room.

At this time plastic bags were a 'restricted item' on the ward, but Joshua's family had not been told this.

On the 15 August 2019 Joshua was transferred to Northgate Ward, another ward within Wedgewood House.

On the 9th September 2019 at 17:07 Joshua was found in his room with bed sheet around his neck and the plastic carrier bag over his head.

CPR commenced by staff based on the ward and they were subsequently joined by paramedics.

Despite resuscitation attempts recognition of life extinct was timed at 17:45.

At the time of his death Joshua was on hourly observations on the ward.

5 CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters given rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you;

the MATTERS OF CONCERN;-. –

relate to the communication of what are 'restricted and contraband items' to the family and friends of a patient, before those family and friends visit the mental health ward.

This would be particularly important for a family or friends first visit to the ward.

The court was told that there are signs up at the entrance of the ward detailing items that

are ‘contraband’. These items are not allowed onto the ward in any circumstances.

This makes it clear to all visitors what cannot be taken onto the ward in any circumstances.

However, the court was told that a ‘restricted item’ regime also exists, under which patients are risk assessed, with some being allowed particular items (such as mobile phone charger leads, laptop leads, belts and lighters), whilst others are not.

From the evidence we heard in this case, we know that Josh’s clothes were taken onto the ward in a plastic carrier bag, which at the time was a restricted item.

We heard that the bag was emptied, the contents were searched, re-packed and then taken to Josh’s room.

From the investigation into this matter, it is apparent that firstly, that had the family known that a plastic carrier bag was a restricted item, it would not have been taken to the hospital in the first instance.

Secondly, that had the family been aware that a plastic carrier bag was a restricted item, even though they may have used one to deliver Josh’s clothes, they would have drawn staff attention to the bag when it was subsequently taken and left in Josh’s room.

During the evidence no clear system or procedure was identified, for a family to be notified of any particular items that have been deemed ‘restricted’ items for their loved one to have in their possession.

There was therefore no effective communication with the family regarding what items were, and what items were not, allowed onto the ward in Josh’s case.

I am therefore concerned that families and friends of current in-patients, may still inadvertently take a particular item onto ward, or be aware that their loved one has a particular item in their possession, yet be totally unaware that that particular item has been risk assessed as a restricted item for their loved one.

It is known that families and friends of in-patients can play a vital role in their care, treatment and recovery. However, without knowing what have been deemed ‘restricted items’ for their loved one, the ability to assist in keeping their loved one safe whilst an in-patient, is effectively removed from those family and friends.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken in order to prevent future deaths, and I believe you or your organisation have the power to take any such action you identify.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 4th November 2021 I, the Senior Coroner, may extend the period if I consider it reasonable to do so.

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. Mr Joshua Sahota's next of kin.

I am 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

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Nigel PARSLEY
Senior Coroner for
Suffolk
Dated: 09/09/2021