ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Leeds and York Partnership NHS Foundation Trust**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (East).
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 23 September 2020, I commenced an investigation into the death of Neil Peter Bastock, aged 57. The investigation concluded at the end of the Inquest on 1 November 2021. The conclusion of the Inquest was Suicide due to [redacted]
4	**CIRCUMSTANCES OF THE DEATH** Neil Peter Bastock had a medical history of paranoid schizophrenia involving numerous incidents of attempting suicide and self-harming behaviour. He was detained under Section 2 of the Mental Health Act 1983 on 8 July 2020, and admitted to the Newsam Centre. On 17 September 2020, when the (then Section 3) was rescinded, On 20 September 2021, Mr Bastock committed suicide by [redacted]
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 decision to rescind the section on 17.09.2020 was made: a. by a responsible clinician who had been in this role for only two weeks. b. his family were not involved in the decision at all and only became aware of it after it had been made. c. no formalised assessment of his mental capacity was made prior to the decisions. d. his care plan had not been updated. e. the pressure on bed availability in the Newsam Centre may have influenced the decision. 2. Mr Bastock's treatment in the Newsam Centre lacked continuity. The

	responsible clinician was a locum who had recently taken over from another locum psychiatrist. There was no ward manager on the ward to provide leadership for the care being provided. There was no psychologist on the ward to contribute to care planning. The nursing records were incomplete, possibly due to teething problems associated with the recently introduced electronic recording system. 3. When the section was rescinded, Mr Bastock became a voluntary patient on the ward. In the three days following 17 September 2020, various factors should have triggered a need to reconsider the decision, including: a) Mr Bastock left the ward on occasions and once did not return until 5am. b) On his return, there was no recorded evaluation of his situation and what action was required from the team treating him. c) A family member voiced concern that he was unwell and was not ready to be discharged, yet this warning was not heeded. d) Another family member reported that he had gone to his former partner (whom he had not seen for several years) to give her £250 he had withdrawn from a cash machine for his children. The possibility that this act amounted to a farewell gesture was noted in the nursing record, but its significance was not sufficiently considered. e) Mr Bastock had indicated he felt unable to live alone. Although a social work assessment had taken place, no plan in relation to alternative accommodation had materialised. In the absence of such transition infrastructure, it was premature to consider him for discharge from the section. f) When Mr Bastock left the ward, there was a failure to notify the police of him as a missing person, given his suicide risk (irrespective of whether this complied with the prevailing missing person's policy stipulated timescales).
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 7 January 2022, 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 following Interested Persons: [redacted] (daughter) [redacted] (sister) [redacted] (sister) 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	1st November 2021 Signed: Kevin McLaughlin