REGULATION 28: REPORT TO PREVENT FUTURE DEATHS .

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THIS REPORT IS BEING SENT TO:

- Medical Director, North Manchester General Hospital
- Medical Director, Manchester Mental Health and Social Care Trust

Copied for interest to:

- The Family of Nicholas Patrick SULLIVAN (Deceased)
- The Care Quality Commission
- The Manchester CCG's
- The Medical Director of the NHS
- The Secretary of State for Health

1 CORONER

I am Nigel Meadows, H.M. Senior Coroner for the area of Manchester City.

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 INQUEST

On 10 December 2014 I opened an investigation into the death of Nicholas Patrick SULLIVAN. The investigation concluded at the end of the inquest on 15 August 2016.

The cause of death was found to be:
Ia Traumatic brain injury
Ib --
Ic --
II Schizophrenia

The conclusion of the inquest was:

Narrative Conclusion: The deceased suffered from a chronic and enduring mental illness, namely Paranoid Schizophrenia, which was remitting and relapsing in nature and treated by depot and oral medication with which he was compliant. Despite this he was prone to rapid deterioration in his mental state and on the 10/11/2014 he suffered an acute deterioration in his mental state and attended an emergency department of a hospital and he was reported to be expressing suicidal ideation and suffering auditory hallucinations. He was not triaged by a nurse nor referred for a mental health assessment in a timely and appropriate manner but left the hospital after a period of time when his condition seemed to have improved accompanied by family members. Some hours later he expressed general suicidal ideation and ran across a highway and then stopped in the middle of the road before he was hit by a car which could not have avoided the collision. It was not possible to determine whether he had deliberately intended to cause his own death by his physical actions. He died some time later from the injuries sustained.

4	**CIRCUMSTANCES OF THE DEATH**

Sadly, the basic background circumstances echo the Court's previous experience in Manchester, but also some 10 years ago in *R(Takoushis) v HM Coroner for Inner North London* [2004] EWHC 2927 Admin.

He was well known to psychiatric services and had previously been admitted to mental health units, both on a voluntary basis and compulsorily detained under the Mental Health Act. In March of 2014 he suffered an acute deterioration in his mental state and was taken by his mother to the Emergency Department of North Manchester General Hospital. This resulted in an admission to a psychiatric unit lasting about three weeks, before he was discharged. He had a long term care coordinator, with whom he had a good working relationship. He enjoyed a period of stability for a few months, before there was a further rapid deterioration in his mental state in August 2014. Once again this resulted in his mother taking him to the Emergency Department at North Manchester General Hospital. This in turn led to his admission to a psychiatric unit for about ten days, before he was then discharged. The hospital computer system indicated that he had a history of 27 previous admissions.

His responsible clinician changed in September 2014 and he saw him for a review appointment. At this stage he was being given monthly depot medication, supplemented by a small amount of oral medication. The deceased presented very well at the review appointment. On 6 November 2014 he saw his newly appointed care coordinator for the first time and presented as being quite well and stable. He was cooperative and wishing to engage with services. He had also just had his monthly depot medication administered. He attended a family meal on 9 November 2014 when he appeared to be quite well.

At about 16.30 hours on the 10 November 2014 he attended his Mother's home and was in an obviously agitated state and was voicing suicidal ideation. His sister phoned the Crisis Team at about 5.00pm and was advised to seek assistance from his GP or alternatively take him to the Emergency Department at North Manchester General Hospital.

The family opted for the latter and he arrived at about 5.15pm and was booked in by reception at 5.18pm by his sister. She was particularly concerned about his presentation because she had not experienced him expressing suicidal ideation before. Prior to arrival he had consumed a tablet of Zopiclone. He remained outside for significant periods of time, as the Emergency Department was particularly busy.

He was meant to be triaged within 15 minutes but was never seen. After waiting over an hour he indicated to his family members who were present that he was feeling a little better and described himself as "healed". He wanted to leave and go to his mother's address. His sister spoke to the receptionist again to point out that he had been suicidal and had not been seen, but now wanted to go home. She was directed to speak to a member of staff. It is recorded in the Emergency Department's computer records that he left the Department after 1 hour 19 minutes.

He ingested a tablet of Zopiclone medication and was taken by his sister to the Emergency Department of North Manchester General Hospital, which had experienced excessive demand for services from about 10.00 hours. There had been a serious and significant failure to trigger an escalation policy at the hospital and set up a secondary triage point and seek additional resources. The deceased was booked into reception by his sister at 17.18 hours and the receptionist was told that he was suicidal and was suffering auditory hallucinations, although she only recorded that he was hearing voices. The Court found as a fact that the receptionist had been told he was suicidal. He was not suffering from any physical condition requiring assessment or treatment and was meant to be triaged by a nurse within 15 minutes, but he was not seen at all in a period of about 1 hour 19 minutes despite his sister reminding the receptionist that he was suffering from suicidal ideation and speaking to a member of the nursing staff.

	There was a serious and significant failure to ensure that he was triaged in accordance with long established national guidelines. Had he been so then he would have been referred for a mental health assessment to be undertaken in the Emergency Department by a mental health nurse. At the time, the mental health team were located in a portacabin and not within the Emergency Department. The deceased indicated that he was feeling better and wanted to go home. He returned to his Mother's address and consumed two further tablets of Zopiclone and went off to sleep. He awoke some time after 22.00 hours and told his Mother that he wanted to get some fresh air and go to a local shop. He reiterated that he felt suicidal. A short time later he left that address and at about 22.48 hours on 10 November 2014 the deceased ran across the carriageway in Rochdale Road, Blackley, Manchester near to Smethurst Street, but came to a sudden halt in the carriageway and was in collision with a motor car. He sustained multiple serious injuries and was taken to the Salford Royal Hospital for assessment and treatment of a serious head injury but died there on the 30 November 2014. On the evidence it was not possible to conclude that despite the serious and significant failures to initiate the escalation policy and/or triage him or make a consequent and necessary mental health referral that he probably would have survived or his life would have been prolonged. The records suggest that he was going to see his GP but the family indicated that they actually said they would try and contact his CPN. The Emergency Department had been experiencing excessive demand for their services from about 9.00am that morning, which should have triggered the initiation of the escalation policy and setting up of a second triage point. It seems that by late afternoon the national standard of 15 minutes to be triaged from arrival was being missed for a number of patients. The deceased suffered from no physical condition requiring assessment or treatment but if he had been triaged it is obvious that he would have been referred for a mental health assessment. The available mental health staff on duty that day had also experienced significant demand for their services and there was one Registered Mental Nurse on duty who would ordinarily undertake the assessments. On arriving home the deceased ingested two further Zopiclone tablets and then went to sleep, but awoke shortly after 10.00pm. Sometime after 10.3 pm he told his mother that he needed to go out and have a breath of fresh air and was also going to visit a local shop. He reiterated that he was still having suicidal thoughts. At 10.48 pm, a short distance away from his mother's address, he ran across Rochdale Road but then came to a sudden halt in front of moving traffic and was hit by a motor car. He sustained serious injuries and was then admitted to the Salford Neural Head Injuries Unit for further assessment and treatment. Sadly, his condition deteriorated and he died on 30 November 2014.
5	<u>**CORONER'S CONCERNS**</u> 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: 5.1 Whilst recognising that Emergency Departments can by busy, reception staff did not work to a short bullet point pro-forma checklist which identifies issues of mental disorder/conditions and check and record important background issues, such as self-harming behaviour or suicidal ideation. This information is vital to record and should trigger urgent triage/mental health assessment.

5.2 There was no clear system to trigger urgent triage and safeguarding steps prior to that.

5.3 There was no clear system following triage and mental health assessment referral, to safeguard the patient pending that assessment.

5.4 There should be a clear and well-understood escalation policy which is activated appropriately.

5.5 Consideration should be given to co-locating mental health staff in the Emergency Department.

5.6 Consideration should be given to having a suitable safeguarding room(s) available.

5.7 Both Hospital Trust and Mental Health Trust staff should be able to access their respective computer systems.

5.8 Consideration should be given to training hospital reception staff, clinical and nursing staff about the issues that arise from patients attending, presenting with either acute mental disorder or mental health problems, and how best to triage and safeguard these individuals.

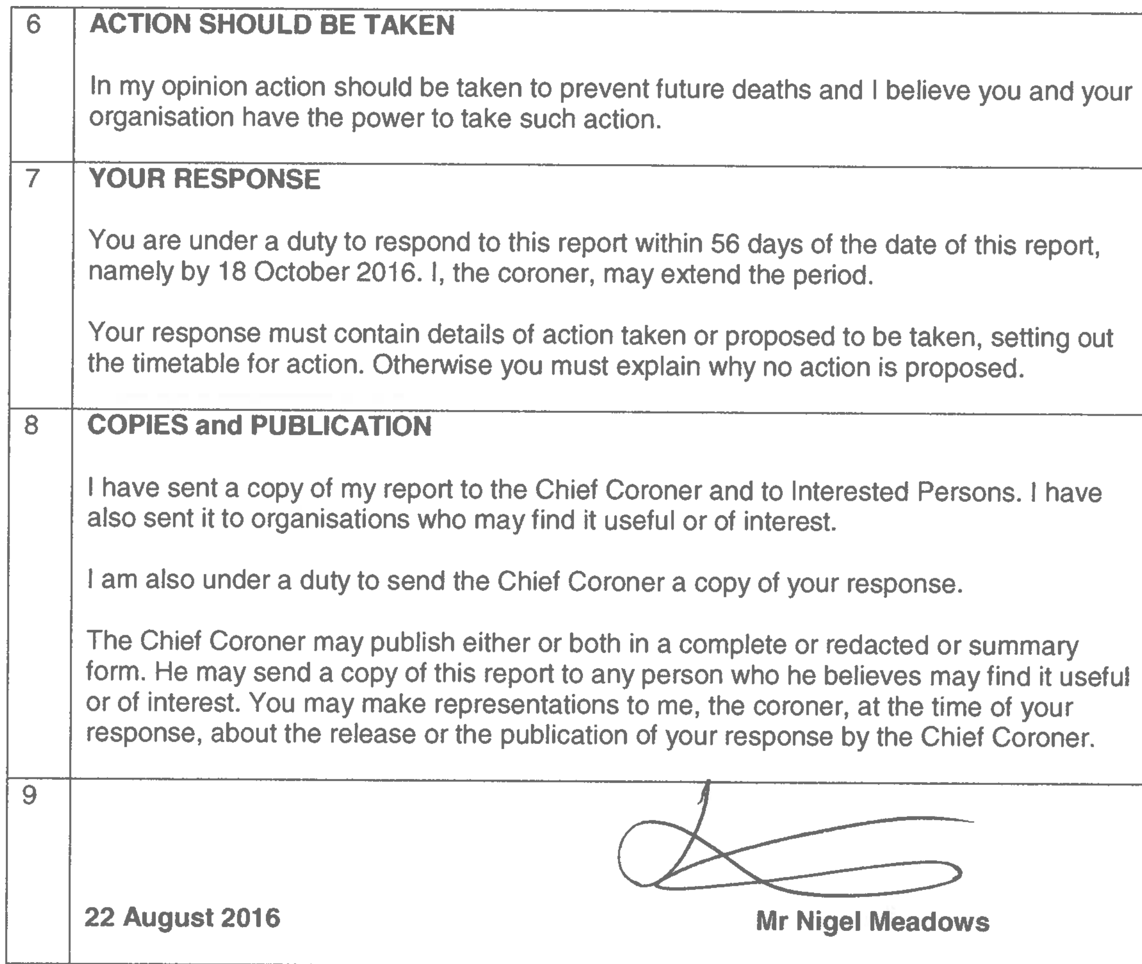
5.9 Both the Hospital Trust and the Mental Health Trust should consider having simple working protocols between them.

5.10 The Mental Health Trust should consider whether the staffing is sufficient to meet the needs/demands of the service.

5.11 Both Trusts should consider utilising a simple urgent alert system for patients with an acute mental health presentation that can be accessed and acted upon even before an initial triage by hospital nursing staff by mental health staff.

5.12 <u>SUI / HLI / CLI reports</u>

- Serious Untoward Incident / High Level Investigation / Comprehensive Incident Investigation reports must be initiated as soon as possible after the events and adequate terms of reference formulated.
- All relevant records need to be identified and retained.
- Appropriate personnel to participate as members of the investigation panel must be identified.
- All relevant witnesses must be identified and statements obtained from them at the earliest opportunity.
- The investigation panel must decide which witnesses need to be interviewed and/or further information requested from them.
- If interviewed there is either an audio recording or other written account of all issues addressed, questions asked and responses. The interviewee is then given copies and invited to check and verify the record.
- Any investigation which involves a fatality must have priority.
- Any formulated report must address the terms of reference and make findings of fact about the primary or central issues.



6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 18 October 2016. 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 Interested Persons. I have also sent it to organisations 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	**22 August 2016** **Mr Nigel Meadows**