IN THE NOTTINGHAM CITY AND NOTTINGHAMSHIRE CORONERS COURT

BEFORE HM ASSISTANT CORONER ALEXANDRA POUNTNEY

IN THE INQUEST TOUCHING THE DEATH OF

KAINE REGAN FLETCHER

(Referred to as Kaine, at the request of his family)

DECEASED

ISSUES LIST FOR BOX 3

I have prepared a list of key issues for you to consider when reaching your findings of fact. You may reach findings on all or some of the issues, as you see fit. There might be other issues on which you wish to reach findings, and if so, you are permitted to include those in Box 3.

You must record any fact upon which you intend to base a shortcoming or failure by one of the IPs. As this is an inquest in which Art. 2 ECHR is engaged, you must record in Box 4 any failings or shortcomings that you consider have probably, or possibly, contributed to Kaine's death. You must therefore record as a finding of fact the evidential basis upon which can you go on to come to that conclusion in Box 4.

It is up to you how you set out your findings, but you might consider the following structure to be a logical approach.

Please consider the following issues and provide your answers on the balance of probabilities:

Section 1: Kaine's relevant medical history

- Kaine's relevant medical diagnoses of Paranoid Personality Disorder and Substance Misuse
- Kaine was in good physical health with no underlying medical conditions

Section 2: Kaine's interactions with the LMHT and substance misuse between February and June 2022

- The interactions that Kaine had with LMHT and what he was asking for by way of treatment
- Whether there was a missed opportunity to prescribe Olanzapine at the MDT meeting on 15 June 2022

- Whether there was adequate support in place following Kaine's discharge from LMHT

Section 3: the events of 2 July 2022

- Why the police attended Kaine on 2 July 2022
- Kaine's presentation on arrival of the police
- Whether the police had a plan to detain Kaine under s.136
- Whether that plan changed following the input from the Street Triage Team, and particularly after the assessment from the Community Psychiatric Nurse
- Whether the police relied upon the assessment of the Community Psychiatric Nurse
- The actions and input from the ambulance crew
- What assessments/checks were carried out by the Community Psychiatric Nurse and the ambulance crew and whether they were adequate
- What was the ultimate outcome for Kaine on 2 July 2022
- Whether this outcome was a reasonable one based on proper assessment and evidence
- Was there agreement between the police, street triage and the ambulance service as to a plan for Kaine on 2 July 2022

Section 4: the events of 3 July 2022

- The calls to emergency services from Kaine's family
- Why the police attended Kaine on 3 July 2022
- Kaine's presentation when police arrived at the YMCA and whether it was materially different to his presentation on 2 July 2022
- The circumstances around Kaine's detention
- The restraint of Kaine
- Kaine's development of ABD
- The timing of the police calling an ambulance and whether this should have been earlier, including any policy that required the police to call an ambulance for a detention under s.136
- Kaine's transport to QMC

Section 5: briefly explain, where, when and how Kaine died

- The events at QMC

Section 6: Culture and Systems for police, ambulance service and Mental HealthTrust

- Whether you consider that there were any issues with the culture and systems for the above agencies which played a part in Kaine's case
- Whether you consider that information dissemination, or a lack thereof, played a part in Kaine's case
- Whether you consider guidance or training, or a lack thereof, played a part in Kaine's case

- Whether you consider management and leadership, or a lack thereof, played a part in Kaine's case

An example of a Box 3 finding in a fictitious case

Peter Jones was an inpatient detained at Seabrooke Secure Mental Health hospital, Leicestershire, pursuant to s.2 of the Mental health act 1983. His detention was authorised on 5 May 2020.

Peter was discovered unconscious on the floor of his locked bedroom (room 12) on the Tintagel ward by nursing staff delivering breakfast medications at around 08.00 hours on 6 June 2020. Emergency medical first aid was provided which discovered that Peter's heart had already stopped, and he could not be resuscitated. He was declared deceased inside bedroom 12 at 08.24 hours that morning.

Peter's death was caused by morphine toxicity which he deliberately consumed with the intention of bringing about his death.

An empty bottle of Oramorph, a form of liquid morphine, was found hidden in Peter's room after his death. Oramorph is a controlled medication, and Peter ought not to have had access to this substance at any time while in hospital, as he was not prescribed the same, nor would he had been permitted possession of such. It is not known how or when he came to possess the Oramorph, but it was derived from the Trust's stock and therefore there had been a failure to ensure controlled substances were kept securely aware from patients. Peter probably consumed the substance after he retired to bed at 11pm the night before he was declared deceased.

Oramorph toxicity probably led to Peter becoming drowsy over a period of hours, and then slipping into unconsciousness before his heart stopped.

Peter was not subject to any observations overnight, nor did his room have CCTV, so it is not known exactly when he died, but it must have been after 23.00 hours when he was las seen fit and well by nursing staff, and before 08.00 hours when he was discovered.

Peter had made disclosures to staff of feeling suicidal on 5 May 2020, 15 May 2020, 18 May 2020, 22 May 2020 and 5 June 2020, and contrary to national and local policy, Peter was not subject to a suicide prevention care plan at any time leading up to his death.

Between Peter's arrival at Seabrooke Hospital and his death, the Senior Clinical Team had all left their employment, and while recruitment was ongoing to fill these important posts, more junior staff were managing the hospital without the necessary and appropriate supervision and leadership. This probably impacted the safety of the hospital with regards to medication control and the management of Peter's risk of suicide.