CORONER'S COURT

FALKLAND ISLANDS

Case No: COR/03/20

In the matter of an Inquest touching upon the death of

# ROBERT JOHN WILKINSON (DECEASED)

Before Her Majesty's Coroner Mrs S Whitby on the 16th and 17th and 18th June 2020

## Conclusions and Verdict

1. The Inquest into Mr Wilkinson's death, whom I will now refer to as Robert, took place over two days on the 16th and 17th June 2020 when evidence was heard and submissions and concluded on the 18th June when I gave conclusions and verdict. I opened the inquest on the 19th March, confirmed Robert's identity at that hearing, and held two pre inquest hearings ('PIH') on the 20th May and the 10th June.

2. Robert's family, his mother father and sister, have all attended, represented by Mr Mark Lewis. Falkland Islands Government ('FIG') have been represented by Mr Stuart Walker.

3. I have heard evidence from Dr James Hickman (read), Mrs Dot Gould, Dr A Murphy, Community Psychiatric Nurse ('CPN') Michael Norman, Nurse Loretta Webb, Senior Police Constable M Dalton, Dr M Fry and Chief Nursing Officer ('CNO') Mandy Heathman.

4. The pre inquest hearings were concerned primarily with the matter of;

   (i) whether the European Convention on Human Rights (ECHR) applied in the Falkland Islands, and whether it was at odds with the Falkland Islands Constitution in its application of the 'Right to Life' under article 2 and

   (ii) if there was an arguable case, that the operational and systemic duties under article 2, owing from FIG to Robert were breached by FIG, leading to the need for an inquest that asked 'How and in what circumstances Robert came by his death' therefore satisfying the procedural demands of article 2.

5. The position of the properly interested persons prior at the second PIH is that FIG accepted that Robert was owed both the systemic and operational duty in accordance with the tests set out in *Rabone v Penine care NHS Foundation Trust 2012 UKSC 2* and *Fernandes de Oliveira*

*v Portugal 2019 App No 78103/14.*It was accepted that for there to be an operational duty owed, the person to whom the duty could be owed, is in control of the state, a vulnerable person, and one who is at risk of committing suicide. The additional factors that assist the state in recognising that there is a duty are that there is present;

a) A history of mental health problems
b) The gravity of the mental condition
c) Previous attempts to commit suicide or self -harm
d) Suicidal thoughts or threats
e) Signs of physical or mental distress

6. The submissions on behalf of FIG, for the PIH on the 10th June, at paragraph 24, confirm acceptance that the systemic and operational duty was owed, the former because Robert 'was a patient at KEMH and FIG owes to all patients at the KEMH, an overarching obligation to provide a system of care that protects the lives of patients' and the later because Robert 'was an especially vulnerable patient who was at risk of suicide'. This was agreed by Mr Lewis. There was disagreement as to whether there was a 'real and imminent risk' that was not recognised or if recognised not acted on such, as to then lead to a breach of the article 2 duty.

7. I provided a substantive judgment after the second PIH, dated the 11th June 2020 when I reviewed the law and factual matters such as I was able to do so in the absence of hearing evidence. In conclusion I decided that I could not say for certain that there was an arguable case of breach of the systemic and operational duty that was owed, but that a wider inquest was needed to explore areas that may disclose evidence of breach and to ensure that I explored adequately the circumstances of Robert's death, as justice demanded.

8. In that judgment I have carried out a review of the law and I do not intend adding to what I have said already save to mention a case very recently decided *R (Maguire) v Her Majesty's Senior Coroner for Blackpool & Fylde 2020 EWCA Civ 738* provided to me by Mr Walker. This case was another of a series exploring when the operational duty arises. The young woman who died, lacked capacity and was subject to a DOLS (Deprivation of Liberty Safeguard) under the Mental Capacity Act 2005. She lived at a privately run care home under the umbrella of a Blackpool local authority. The argument was primarily whether you could equate a person who was in the control of a hospital either voluntarily or involuntarily with a person who lacked capacity and was subject to a DOLS such that both could be owed the operational duty. I am content that this new case does not affect the outline of the law and the tests I need to apply in this matter and which I identified in my judgement of the 11th June.

9. This judgment considers the key issues and factual questions that were to be answered as decided, at the pre Inquest hearing on the 20th June 2020 and which are;

a. Risk assessment and care planning and recording for Robert Wilkinson;

b. Was there a point at which the risk of suicide was recognised or should have been recognised?

c. Was that risk 'real and immediate'?

d. Was there proportionate action that the hospital could have taken to manage or reduce the risk?

e. Is a Preventing Further Deaths report required?

10. In my judgment of the 11th June, I have reviewed the evidence as presented to me in document form both the statements and medical records. This judgment will review the evidence presented at the inquest, clarify evidence that I now know to be wrong, or unclear and draw facts from the evidence upon which I will rely for the conclusions for completing the inquisition.

11. Review of the evidence. Both Mr Lewis and Mr Walker were able to cross examine the witnesses.

(i) I heard the statements read, made by Dr James Hickman (1IB) which I accepted as giving a cause of death of 1a. Cerebral hypoxia 1b. Hanging and 1c. Clinical depression. I also accept that Dr Hickman interacted with Robert on the morning of the 17th March and there was 'nothing about his demeanour or conversation that morning that raised any particular concerns that he might be planning or considering the actions that later sadly led to his death'(3aIB).

(ii) I had verbal evidence from Dot Gould who is Robert's sister. Mrs Gould said that she had seen her brother in hospital on the 30th January just before she flew to the UK. Robert told his sister that he had looked into suicide, that he did not want to be here anymore. He repeated this when Mrs Gould visited him again on the 14th February, and said he wished that he had succeeded with his suicide attempt on the 8th February. Mrs Gould was concerned to find a knife in Roberts every day coat after his death and was aware that her father had asked the hospital to be aware that Robert could be carrying a knife about with him. Mrs Gould was able to confirm the handwriting for a note dated 5th February 2020 in a notebook left in Robert's hospital room. This note in summary clearly says that Robert intended taking his own life. Neither the interaction with hospital staff over the knife nor the distress that Dot Gould showed at the hospital over her brother voicing suicidal intent were recorded on Roberts hospital notes.

(iii) CPN Michael Norman was a mental health nurse who had been part of the team caring for Robert. He is in the Community Mental Health Team and not a ward nurse. He had been told about the knife that Dot Gould and her father had found but felt that if Robert denied having it, which he did, it was not of very great concern because Robert had never self -harmed by cutting and he had not used a knife in his previous suicide attempt. He does not document his conversation with Robert about the knife.

Michael Norman confirmed that there was a number of recording processes at KEMH, EMIS an older system and a new system called Patient Source (PS). The ward recordings by nurses are on PS. This system should be used for all patient and health recording but is not yet in use hence the dual system Mr Norman said he did have some difficulty accessing PS but he would get verbal updates from the nurses. He said his involvement with Robert

was fractured, not continuous. He would know what was happening with Robert by verbal liaison. He attended Dr Whittle the visiting psychiatrist with Robert on the 12th February, and knew of her care plan for him to include a change of medication from Mirtazapine to Sertraline, concern that he should remain at the hospital, that he should have a nurse interact with him, and for psychiatric nurse input and a monitoring of his medication. He gave advice to the nursing staff on the nature of that interaction which should not be heavy handed but woven into general chat. The significant features of the assessment by Dr Whittle says Mr Norman, are Robert's very recent suicide attempt, his despairing demeanour, his low mood, his limited interaction with staff, and the fact that he had concealed his suicide plans recently.

Robert has a gradual increase in escorted leave out of the hospital to a point where unescorted leave is considered.

Mr Norman produces two further written care plans following review meetings one on the 28th February and one on the 8th March after a meeting on the 6th March (205-210 IB). He produces these care plans as he thought the care plans would make things easier and he made them available to the ward where Robert was. Under these care plans, he supervises an increase in unescorted leave in a period when the lead mental health specialist Dr Murphy, was away. Dr Murphy had started the unescorted leave on the 4th March, Dr Murphy was away from the 4th March to the 12th March, and left Mr Norman to continue to manage the unescorted leave. Mr Norman reports in his statement of the 26th April that he was conscious that the change to unescorted leave was a high risk period in Robert's recovery. When asked about this he said that this meant high risk generally, to include specifically high risk of increase in anxiety. He says that assessing risk is difficult and the assessment process is ongoing.

The unescorted leave increased to one hour on the 9th March with a monitoring call on the half hour point. The monitoring call was to break any difficult suicidal thoughts that might become a problem to resist and connect him with another person. Robert wanted more unescorted leave but Mr Norman thought that more would be too much at that point. He agreed that the leave can increase risk, that you acclimatise to the unescorted leave, that anxiety can then reduce and there is a risk from greater motivation that Robert was showing. It was a balance of Roberts wishes, the need to avoid institutionalisation and the harm that time in the hospital could cause. On the 12th March the contact was at one hour still. It is unclear if the half hour phone call was still happening from the notes, Mr Norman thought it would have been. He says that he thought that the care plans would make things easier and calling the care plan meeting was a way of bringing those involved in Robert's care together. The care plan of the 8th March was made available to the ward nurses.

He says that assessment of risk is difficult, that the risk assessment was part of the increase in the unescorted leave, and the unescorted leave was a risk of suicide against the need for Robert to have time away from the hospital. Mr Norman said he did not continue to monitor leave after the 9th March that would be left to the ward staff. He would have got involved if asked to and he says he interacted with Robert on the 9th and 10th, though the

latter interaction is not noted as to its content. *In my judgment of the 11th June I state that the last interaction was on the 9th March*. Dr Murphy came back into work on the 12th March and the unescorted leave was increased to three hours the day after. Mr Norman said he would have talked to Dr Murphy about Robert and his leave but this is not documented anywhere. He cannot remember specific conversations about the extension of leave nor about midway phone calls.

Mr Norman agreed that he and Dr Murphy do not, in their other jobs away from FIG, usually have the need to record and log down care plans and they have different approaches. The need to record means you do it in different ways. There is no protocol about recording and care plans at the hospital.

(iv) Dr Murphy explained that she was clinical psychologist who had first contact with Robert in December 2019 as a colleague asked her to assess Robert. Robert presented with increasing suicidal ideation, until on the 30th January 2020. Dr Murphy suggested he become an inpatient again in order to keep him safe. Dr Murphy did not believe there was any need to section Robert because he had capacity, and agreed to stay at the hospital. Robert remained in hospital voluntarily. At no point did he attempt to leave, Dr Murphy thought he wanted support, and lacked motivation to leave. She also thought he feared being sectioned and this continued until his death.

Dr Murphy was the lead mental health professional for Robert which was acknowledged at the ward round meeting on the 7th February. Dr Murphy said that this did not really change anything.

Robert made a suicide attempt on the 8th February using carbon monoxide when away from the hospital at home.

A risk assessment was completed by Dr Murphy with Robert (69-73). This appeared to not have very much weight in the assessment process for risk. More important was the day to day risk assessment that is unrecorded as a formal risk assessment. Dr Murphy continued to record her care plans on EMIS. Dr Murphy said that the fact there were difference systems of care plan recording was not a problem. There was an overarching constantly evolving plan, and a verbal up date to the ward staff. Dr Murphy was happy about how the plans for Robert were working and she knew this more from the verbal hand over than notes.

Robert would engage with Dr Murphy, but he did not tell her everything which she realised.

Dr Murphy led the change of plan from escorted leave to unescorted leave. Unescorted started on the 3rd March with 30 minutes away. At this point Dr Murphy thought that Robert had moved from being at a real and immediate risk of suicide as on the 30th January. The intensity of the suicidal thoughts were less, he was more able to do psychological work, he was getting frustrated and he was no longer saying that he was bothered that the suicide attempts had failed. There is a clear careful plan to start the unescorted leave (109 IB).

Anxiety was increasing thought due to a medication change that occurred after the visits to Dr Whittle. Dr Murphy says that it was not surprising that Roberts anxiety levels increased as the mood levels improved following the change in medication.

The next increase in unescorted leave takes place when Dr Murphy is away, from the 4th to the 12th March, to one hour and on her return increases the day after to 3 hours with no phone calls. Dr Murphy says that there was a phased increase, she did not think that Robert was at risk because the increase was a reasonable compromise between what he wanted and what was sensible. Dr Murphy thought the unescorted leave had already increased to two hours, that the removal of phone calls was discussed with the ward staff and Robert and that there would have been discussion with Mr Norman on the increase though this is not documented. It is recorded that Robert was late back on the 13th March by 45 minutes, Dr Murphy said that she was not aware that Robert was late back. Dr Murphy said she had asked the ward staff to have a debrief with Robert after he returned from this unescorted leave. This debrief is not recorded. Robert has unescorted leave again on the 14th and 15th which is the weekend. There are no concerns raised by the ward staff.

On the 16th March, Dr Murphy does not attend the ward round and neither does Mr Norman. Dr Murphy sees Robert briefly. The notes (107IB) say that Robert is very anxious and wringing his hands. Dr Murphy says that this was not unusual. Dr Murphy said she thought he was anxious about going out for a haircut. Dr Murphy said that ideally, a before and after assessment of the extended unescorted leave would be anticipated.

Dr Murphy said that at this point Robert was better than he had been but low, sad, and very lonely. Dr Murphy said he was brighter than he had been, she did not have concerns, it was difficult to engage Robert, she did not think that there were more risk indicators.

On the 17th March Dr Murphy confirmed from her diary that she had attended the morning ward round. *This is not recorded in the notes and I have therefore implied that she did not attend in my judgment of the 11th June*. She remembers telling the staff that with greater motivation in Robert there was a need to be vigilant. This is not recorded in the notes. Dr Murphy said she would see Robert after lunch but he had already left when she returned to the ward. Dr Murphy said that she could not think of anything on the 17th that would have made her want to change the plan for Robert.

(v) I heard from Loretta Webb who is an auxiliary nurse and was on the nurses shift for the ward at KEMH on the 17th March from 7.30am until 15.30am.

Ms Webb said that the routine was there was a handover from the shift before and notes were taken on the nurses cardex. Ms Webb was familiar to Robert. She was aware of the need to interact with him and that normally a qualified nurse would do that. Ms Webb says that Robert was quite good on the 17th March that he was up and showered and had his breakfast. The nursing staff had followed the plan for his leave out of hospital from half an hour onwards and were aware of the changing plan. Robert had to be back by supper. Ms Webb gave him lunch she said he was looking forward to going out. Ms Webb said she also saw him as he left on the 17th as he engaged in talk with her and Mandy Heathman at the nurses' desk as he left.

(vi) SPC Mark Dalton was on duty on the 17th, and was sent to Roberts's house on a welfare visit, when a call came on the 17th March that Robert had not returned to the hospital. Mark Dalton was familiar with the house as he had attended Robert on the 8th February. He found Robert suspended from a ligature in the shed.

SPC Dalton on finding Robert attended to him and began CPR.

He confirmed that there was no indication of a third party involvement. He read his statement to the Inquest, which stands as his full evidence.

(vii) Dr Mandy Fry attends to give evidence on the second day.

Dr Fry is a visiting medical practitioner who usually is in the Falkland Islands working at KEMH for three months of the year.

Dr Fry is the mental health lead for her practise in the UK. On her arrival in the Fakland Islands, Dr Fry was asked to lead the Significant Adverse Event Review as she had not had any involvement in Robert's care at KEMH.

Dr Fry has produced an SEAR report which is at 40-45 IB and that report has recommendations at 43IB. Dr Fry exhibits the action plan to a previous SEAR at 75-80IB. The original date of this action plan (the first action plan) is unknown. Dr Fry also is able to talk about the second action plan that is exhibited to a statement by Dr R Edwards the Chief Medical Officer. This second action plan is at 226-229IB and is very recent. Dr Fry says that the latter mirrors the recommendations made at 43IB and her SEAR. Dr Fry says she does not consider that an external report is required.

Specifically regarding Robert's care, Dr Fry says she did not think it was unusual to have an increase in unescorted leave from 1 hour to 3 hours. Dr Fry accepted this would increase risk as would the increase in Robert's motivation. This had to be balanced.

Dr Fry was not of the view that a clear care leader was needed for patients at KEMH. It was likely there would be a lead but it was not required in order to have one person managing risk. Dr Fry accepted that her chronology was incorrect for its entry for the 3rd/13th March (42IB). Dr Annette Murphy and Mick Norman had not seen Robert every day between those dates. Neither had seen him on the 11th nor on the 7th or 8th March.

Dr Fry accepted that notes were not kept up to date; the ward notes should have recorded interactions at a ward round, specific conversations and discussions such as that of Dr Murphy at the ward round on the 17th March and engagements with the family if they expressed concern about suicide. The second action plan refers to the need to ensure notes are kept properly particularly interactions with mental health patients.

Dr Fry explained that there was a transition taking place in patient records between the EMIS system that was no longer in date and Patient Source (PS). This transition was not going as quickly as wanted. PS had been put to one side for the Covid period and nurses had reverted to writing notes. It was hoped that PS would be used for all inpatient recording in 3 or 4 months.

A review of the second action plan at 226 IB is undertaken. 1a and 1b are linked to PS. It is intended that the initial mental health assessment document at 1b, will be aimed to be used

longer term and give a snap shot of their mental health on admission. Dr Fry considers 3b and says that this a review of the management of planned leave. Dr Fry is unaware of an action listed at 1g in the first action plan (76IB) which states that there are already in place 'specific plans for periods off the ward including absconding'. It is said on the action plan that they were completed in September 2018.

Dr Fry is asked for her view on the risk assessment document used by Dr Murphy at (69-74 IB). Dr Fry is not of the view that a tick box risk assessment is helpful. Dr Fry does not know if it is the risk assessment referred to at 1a of the first action plan (75IB).

Dr Fry accepts that there was a lack of coherence in the care plans, use of care plans, use of EMIS, note taking in three different places, but there was coherence in the care itself. Robert did not have an individual care plan as described at 1g first action plan (76IB) regarding his periods off the ward but, there was a recorded protocol that the police be called, recorded on FRI 13th March 13.9 (185IB). Robert was late back on the 13th March and there is no record that any action was taken.

Dr Fry is not able to say when the Mental Health Strategy Plan commanded by the first action plan for the Islands will be completed. It was due in June 2020 having been delayed Karen Rimmicans Senior Mental Health practitioner is the lead. The Mental Health Strategy is due to review all mental health provision in the islands.

(ix) The Chief Nursing Officer Mandy Heathman gave evidence as the last witness.

Mrs Heathman had cared for Robert as part of a shift pattern where she would do shifts to cover illness or other absence. Her last shift was on the 10th March according to PS but she had interacted with Robert as well including on the 17th March. This is not recorded on EMIS or on PS. Mrs Heathman remembers Robert leaving KEMH on the 17th March. He had some limited engagement but did respond when spoken to and smiled in response to a comment about his hair and continued walking out of the hospital.

Mrs Heathman was able to explain the psychiatric observation charts that were produced. These are the records that she suggests are referred to by Ms Webb as the nurses cardex.

Mrs Heathman said she did not think that the recording of Robert's care was as full as it could be. She is sure that there was interaction daily with Robert as stated in the care plans of Dr Whittle and Mick Norman but it is not written down. Mrs Heathman says there is now a system of logging a patient in or out when they go out on leave, being given a token.

Mrs Heathman said she felt records were important, that nurses are not always technically minded to complete computer records and that the written records currently being used are fuller. Mrs Heathman was of the view that verbal plans can be better, more able to adapt but not having them written down is a problem.

Mrs Heathman also said that if she were assessing Suicide Risk she would prefer to use the Storm suicide system because it is more familiar.

12. This completes a review of the evidence presented at the inquest, save that I also reviewed the notebook that had the note dated the 5th February in it. I confirm that the contents of the note indicate

that Robert had the intention to take his life. If I have failed to mention any particular piece of evidence it does not mean that I have failed to take it into account.

13. In paragraph 56 of my judgment of the 11th June I said there were areas where I was unsure as to certain matters. I am satisfied I have investigated these.

14. Having reviewed the evidence I need to now draw out facts which will answer the issues and factual matters identified in the PIH of the 10th June as needing to be addressed.

These are;

**(a)Risk assessment and care planning and recording for Robert Wilkinson.**

(i) Risk assessment was not a formal process. Although a risk assessment document was completed it was not seen as being important. Risk assessment was an ongoing process informed by continuing assessment. There was no specific discussion about risk between the professionals that was recorded, although there was a lot of verbal interaction about Robert's care. At the point where risk increased when the unescorted leave began and increased there was no written risk plan. At the point when the unescorted leave increased on the 12th /13th March there was no recorded discussion between the two lead mental health practitioners as to the increase nor, any telephone calls that might be required as identified by Mr Norman that might reduce the risk. There was a clear identified need to balance Robert's wish to have a more normal life and to not become institutionalised with his own vulnerability and it seems very likely that with the level of involvement with him that the risk was assessed, discussed and considered but it is not documented.

(ii) Care planning took place for Robert that was both documented in care plans of Dr Whittle, Michael Norman and in the notes entered by Dr Murphy in EMIS. It is clear that there was a lot of verbal discussion of Robert's care at the nurses shift handover, at the daily ward round save for weekends, and when the CMHT came to interact and work with Robert. It is accepted that these differing styles of written care planning appear incoherent, but the care plan itself was connected. The verbal planning that took place was not always recorded.

(iii) There were concerns about recording information.

The following were not recorded:

- interventions with Robert in accordance with his care plan,
- recording of when Robert left for unescorted leave,
- recording of matters discussed at the morning ward rounds,
- recording of relevant interactions with family, both as to concerns over suicidal ideation and dangerous articles in the hospital,
- recordings of discussions over a potential increase in risk with an increase in unescorted leave
- Recording of CMHT staff interactions with Robert

**(b) Was there a point at which the risk of suicide was recognised or should have been recognised?**

I am content that there was a point at which the risk of suicide was recognised and indeed it was recognised by FIG.

At the time of Robert's death he continued to be an inpatient at KEMH subject to a regime that he accepted. Dr Murphy was clear that he continued to remain at the hospital because he wanted support, he feared being sectioned and he lacked motivation to leave, though that was changing. None of the mental health staff caring for Robert were suggesting that he be discharged and the regime he wanted for leave was not being agreed to. There were continuing discussions about what to do if Robert did not return, and I am satisfied that medical staff were aware, from actions and their evidence that the risk was recognised.

**c) Was that risk 'real and immediate'?**

The time at which the risk should be assessed as being real and immediate was on the day of Robert's death.

Robert attempted suicide on the 8th February. It is right to compare how he presented then, to how he presented on the 17th March approximately 5 weeks later, as Robert had talked of suicide often but this was the only known attempt. Just after the attempt, Mr Norman describes the very concerning factors present when Robert saw Dr Whittle on the 12th March; the very recent suicide attempt, his despairing demeanour, his low mood, his limited interaction with staff, and the fact that he had concealed his suicide plans recently. I am told that Robert had improved in how he presented with that risk of suicide in mind. Dr Murphy describes Robert, when the unescorted leave commenced, on the 4th March. Dr Murphy says that the intensity of the suicidal thoughts were less, he was more able to do psychological work, he was getting frustrated and he was no longer saying that he was bothered that the suicide attempts had failed. He was interacting more both with staff and with the outside world with the increase in escorted visits. He was carrying out everyday tasks, washing, eating, showering, and having his hair cut. He had interaction with the nursing staff over the weekend before his death, albeit the reporting is limited. I am reassured that there would have been involvement from staff on this period and I have nothing to tell me that they would not have reported concerns. He had home visits where no one reported any concerns, nor were there reports that he had overstayed his time at home.

Robert was described by Dr Murphy as low, sad, and very lonely on the 16th March. However Dr Murphy also says that she did not have concerns about the leave, and she did not think that there were any more risk indicators. She did accept that there was a risk, that the risk increased with him becoming more motivated but it was a balance.

I do not think that the risk on the 17th March was 'real and immediate'. In coming to this view as well as for the reasons set out above, I am also conscious that the staff at KEMH would have known Robert well, that any change in him would have been noted, that they were concerned about him as shown by the comment made by both Loretta Webb and Mandy Heathman that he looked smart because he had had his hair cut. I think that if there had been something that should or could have been seen it would have been.

In coming to this conclusion I am also conscious that Robert was an intelligent man. Mrs Gould was convinced that he intended taking his own life. It is possible that he had rationalized his own actions and deliberately decided to mislead in order to be able to make the decision he did.

As I have not found that the risk was 'real and immediate' I do not find that there was a breach of the Article 2 'Right to Life' by FIG.

**(d) Was there proportionate action that the hospital could have taken to manage or reduce the risk?**

I have found that there was not a 'real and immediate' risk, therefore, do not need to consider if there was proportionate action that could have been taken.

**(e) Is a Prevention of similar fatalities report required?**

Rule 39 of the Coroners Rules 1995 says

> *If the Coroner believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held he may announce at the inquest that he is reporting the matter in writing to the person or authority who may have power to take such action and he may report the matter accordingly*

I do not consider that I can issue a prevention of similar fatalities report because the circumstances of Robert's death was not linked to any specific action or lack of action by any person or organisation. The wording of this Rule is very specific, and the action that I am addressing must link to preventing fatalities in similar circumstances. As I have not found that there was a 'real and immediate risk' apparent for FIG to take operational action if they could to prevent Robert's death then it would not be logical for me to be able to take action under Rule 39.

However, I do think that this inquest has raised matters of concern at KEMH particularly in the record keeping processes. I recommend strongly that the action plan at 226-229IB produced by the Chief Medical Officer, Dr Rebecca Edwards, is followed.

One of the problems I have found is that the combination of differing reporting systems for care plans, risk assessment, EMIS, Patient Source, and written notes gave the impression of a lack of a coherent system of care. It is clear that a lot of care planning and risk assessment is done verbally, that practitioners had differing ways of recording what they were doing. Once we were able to unravel how these methods worked it was also clear that the care Robert had was good, committed, thoughtful and professionals working to try to find the best route for him.

It is not for me to say how KEMH approach care planning for their patients, whether they use a verbal system, written care plans as Mr Norman did, care plans written on EMIS as Dr Murphy did, verbal plans as Mandy Heathman favoured, an initial mental health assessment as the new action plan suggests, an individual plan for time off the wards as the first action plan says, a risk assessment system as the old plan says, or as Mandy Heathman has introduced a booking in and out system using a token system. However, I will be clear that in my view there does need to be one system, simple, clear and agreed, that is put in place, followed, reviewed and practiced. I think that this is particularly important in the area of risk assessment which I do think needs to be properly recorded at critical moments in a mental health patient care plan.

I do confirm that the hospital had systems of work in place that protected the lives of patients, including proper systems to protect the lives of their mentally ill patients and employed competent staff and I do not consider FIG have breached the systemic Article 2 obligation. I would also like to be reassured that the action plan will be put in place in a reasonable time scale.

**Conclusion and Verdict**

I have a duty to complete the Inquisition and I confirm that on the Inquisition I will record the following;

Name of the deceased; Robert John Wilkinson

Injury or Disease causing death;

1a Cerebral Hypoxia

1b Hanging

1c Clinical Depression

**Time Place and Circumstances;**

On the 17th March 2020, the deceased Robert John Wilkinson, who was an inpatient at the King Edward Memorial Hospital, not subject to the Mental Health Ordinance but under the hospital's control and responsibility, left the hospital for an agreed period of home leave, the leave having been gradually moved from escorted to unescorted and increased in period since a previous suicide attempt 5 weeks earlier. The risk of suicide had been balanced against the deceased wish to lead a normal life, and the need to move away from institutionalised living for his own welfare.

Whilst on home leave the deceased hanged himself, and despite KEMH promptly responding when he failed to return, and the efforts of the police, he was found dead at his home at 2a Brisbane Road Stanley Falkland Islands

**Conclusion**

Robert John Wilkinson took his own life

**Registration details**

Date of Death: 17th May 2020

Place: 2a Brisbane Rd Stanley Falkland Islands

Name and Surname: Robert John Wilkinson

Sex: Male

Age: 49 (17.02.1971)

Rank or Profession and Country: Handyman PWD Falkland Islands

**Cause of Death:**

1a Cerebral Hypoxia

1b Hanging

1c Clinical Depression

Sarah L Whitby

HM Coroner

18 June 2020