H.M. Senior Coroner, South London Area

South London Coroner's Office
Saint Blaise Building, Bromley Civic Centre
Stockwell Close, Bromley BR1 3HU
Telephone 020-8313 1883 Fax 020-8313 3673

The Coroners and Justice Act 2009, Schedule 5, paragraph 7 and The Coroners (Investigations) Regulations 2013, regulations 28 and 29

	REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive, South London and Maudsley NHS Trust** Bethlem Royal Hospital Monks Orchard Road, Beckenham, BR3 3BX
1	**CORONER** I am senior coroner for the coroner area of South London
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 (SI 1629) **Extract from STATUTORY INSTRUMENT 2013 No. 1629** **CORONERS, ENGLAND AND WALES** **The Coroners (Investigations) Regulations 2013** **Report on action to prevent other deaths** 28.—(1) This regulation applies where a coroner is under a duty under paragraph 7(1) of Schedule 5 to make a report to prevent other deaths. (2) In this regulation, a reference to "a report" means a report to prevent other deaths made by the coroner. (3) A report may not be made until the coroner has considered all the documents, evidence and information that in the opinion of the coroner are relevant to the investigation. (4) The coroner— (a)must send a copy of the report to the Chief Coroner and every interested person who in the coroner's opinion should receive it; (b)must send a copy of the report to the appropriate Local Safeguarding Children Board(which has the same meaning as in regulation 24(3)) where the coroner believes the deceased was under the age of 18; and

	(c)may send a copy of the report to any other person who the coroner believes may find it useful or of interest. (5) On receipt of a report the Chief Coroner may— (a)publish a copy of the report, or a summary of it, in such manner as the Chief Coroner thinks fit; and (b)send a copy of the report to any person who the Chief Coroner believes may find it useful or of interest. **Response to a report on action to prevent other deaths** 29.—(1) This regulation applies where a person is under a duty to give a response to a report to prevent other deaths made in accordance with paragraph 7(1) of Schedule 5. (2) In this regulation, a reference to "a report" means a report to prevent other deaths made by the coroner. (3) The response to a report must contain— (a)details of any action that has been taken or which it is proposed will be taken by the person giving the response or any other person whether in response to the report or otherwise and set out a timetable of the action taken or proposed to be taken; or (b)an explanation as to why no action is proposed.
3	**INVESTIGATION and INQUEST** At the time of Nicola's death I opened an inquest. The inquest concluded on 14th August 2013. A copy of the Record of the Inquest is attached. Your Trust was represented at the hearing by [redacted] of Bevan Brittan, solicitors. The family was represented by counsel, [redacted]
4	**CIRCUMSTANCES OF THE DEATH** As set out on the record of the inquest: Nicola Matthews had a long history of borderline personality disorder. She had performed many acts of self-harm, necessitating a number of hospital admissions. On 12 October 2010 she took an overdose of drugs and was admitted to hospital, where she was detained under section 5 of the Mental Health Act. This detention was rescinded by her responsible medical officer on 15th October. Nicola wished to be allowed to leave hospital and was permitted to do so on the understanding that her partner would accommodate her. There was a lack of clarity about the follow-up arrangements but this probably was not causative of her subsequent consumption of drugs at her partner's home later that evening. Her partner woke from sleep at about 01.30h on 16 October to find Nicola unrousable. She was conveyed by ambulance to hospital where she was pronounced dead. Her intentions are not clear beyond reasonable doubt and her actions were probably not accidental.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern that require your consideration. Whilst the matters were probably not causative of

	Nicola's death, they are a matter of concern as it is my belief that other patients may come to harm if allowed to depart in-patient care without clear follow-up arrangements. The **MATTERS OF CONCERN** are as follows. – My concern is about the way in which the outcome of decisions taken by the consultant on the ward round on 15 October 2010 were documented and implemented. The contemporaneous note in the EPJS was conceded to be an incomplete record of everything that was decided on the ward round. Nicola had a long-standing history of borderline personality disorder and was constantly at risk of self-harm. Her acts were frequently impulsive. Whilst she had been sectioned on 12 October, the Section 5 order was rescinded on 15 October at the ward round. Nicola was then insistent on being allowed to leave the hospital. The follow-up arrangements made for her continuing care were not clear and were not documented. Evidence at my inquest suggested that there was no clarity as to what the follow-up arrangements were and whether or not they were made clear either to Nicola or to her partner. In the event, Nicola went home and later that evening took an overdose of medication which resulted in her death. Whilst it is not possible to state that better arrangements for follow-up would probably have made a difference to the outcome, I am concerned to ensure that in future patients who are discharged have a clear understanding of follow-up arrangements. It is important that staff members on the ward who have to handle the departure of the patient from the ward have clarity as to what is to happen. In the case of Nicola, with the period of time between the decision being made and her actually leaving, staff had changed and the contemporaneous documents did not allow the member of staff who escorted Nicola off the ward to have a clear understanding of follow-up arrangements or indeed of the nature of and quantity of medication with which she was being discharged. I suggest that consideration should be given to formulating better advice and ensuring that important decisions are better documented and that follow-up arrangements are made clear and adequately documented.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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, but if you require more time to formulate your response I may extend the period. (See extract of regulations in section 2 above) 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 legal representatives of the family of Nicola Matthews. 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.
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	SIGNED [Dr R N Palmer, Senior Coroner, London South Area] **Date 20th August 2013**