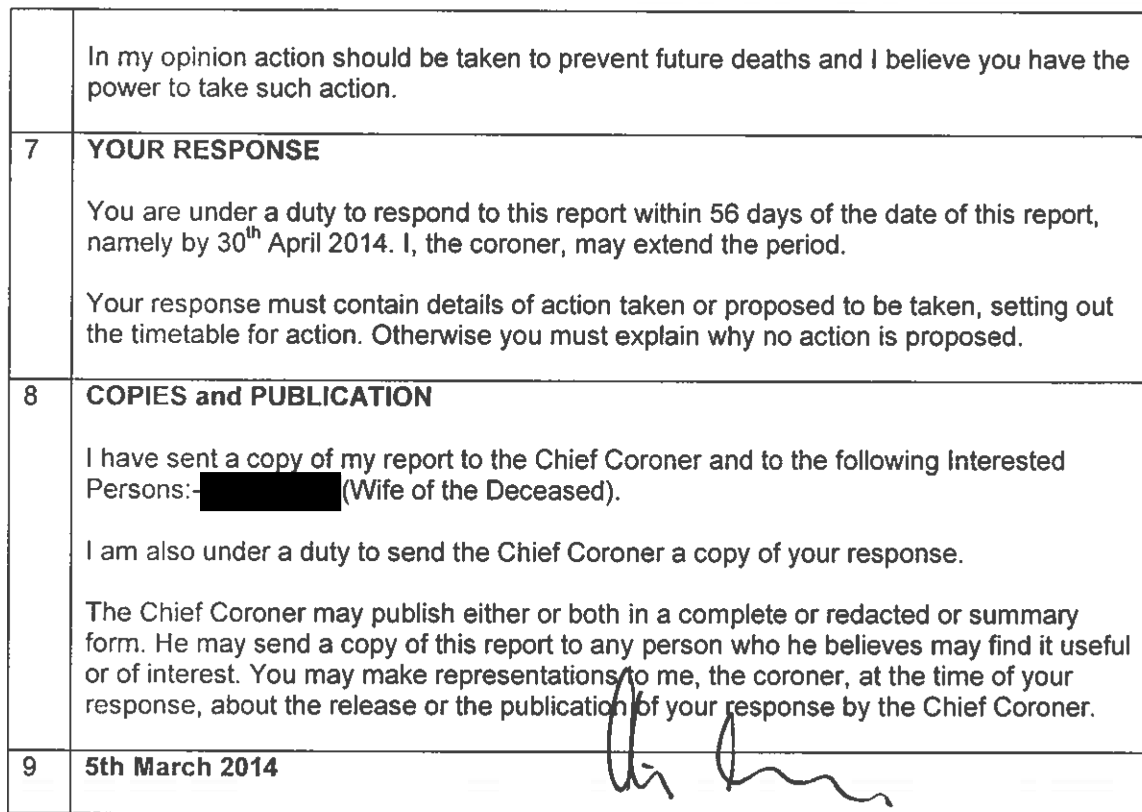
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Chief Executive The Priory Group 2. The Care Quality Commission
1	**CORONER** I am Dr Sean Cummings Assistant Coroner, for the Coroner area of London (Western District)
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 21st November 2012 I commenced an investigation into the death of Neil James Carter date of birth 13/03/1975. The investigation concluded at the end of the inquest on 15th December 2013. The conclusion of the inquest was "Mr Carter took his own life on the 20th November 2012 by jumping in front of a train whilst still an inpatient at the Priory Hospital Roehampton. There were gross failures in his care, notably the failure to perform basic observations followed by deliberate falsification of the record. These led cumulatively to a missed opportunity to realize he was missing, a missed opportunity to search early for him and missed opportunity to offer life saving interventions". The medical cause of death was given as 1a. Multiple Injuries.
4	**CIRCUMSTANCES OF THE DEATH** Mr Carter took his own life on the 20th November 2012 by jumping in front of a train at Turnham Green Undergound Station whilst still an inpatient at the Priory Hospital Roehampton.
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) There were repeated failures to perform basic nursing observations (2) I heard evidence that indicated an enduring situation where the ward frequently had inadequate numbers of staff with an inappropriate skill mix and with an inappropriate layout over two floors. There was a lack of discipline with staff failing to accept a nurse in charge's authority authority. Management was informed of some issues but failed to listen or act. (3) There was a deliberate falsification of the nursing record.
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, namely by 30th April 2014. 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 the following Interested Persons:- (Wife of the Deceased). 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	**5th March 2014**