REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Service Manager,** **Norvic Clinic,** **Northside,** **St Andrews Business Park,** **Thorpe St Andrew, Norwich** **NR7 0HT**
1	**CORONER** I am DAVID OSBORNE assistant coroner, for the coroner area of NORFOLK
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 5 AUGUST 2013 an investigation was commenced into the death of SEBASTIAN VAUGHAN DAVIES, 23. The investigation concluded at the end of the inquest on 25 MARCH 2014 held over two days with a Jury. The conclusion of the inquest Jury was that the medical cause of death was 1a Cerebral ischemia, multisystem organ failure, and developing bronchopneumonia and 1b Opiate excess and they gave a narrative conclusion as follows: "Sebastian died due to an excess of opiates obtained from an unknown source. We believe that procedures operated at the Norvic Clinic could not have prevented his death".
4	**CIRCUMSTANCES OF THE DEATH** At the time of his death Sebastian Vaughan was a detained patient under the Mental Health Act at the Norvic Clinic. On 24 July he was assessed suitable for unescorted leave under a s17 authority in place. On his return no illicit substances were discovered on his person. He retired to bed at 11:00pm. He was unresponsive but breathing the following morning 25 July 2013. Paramedics attended and he was taken to the Norfolk and Norwich Hospital. Sadly he remained unconscious and died at the hospital on 4 August 2013.
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. – Evidence was given at the Inquest that there was a system of hourly observation checks on patients in their rooms during the course of a night shift. These consisted of shining a torch through the window in the door to the room and looking and listening for signs of breathing. However it was not routinely part of such observations to check whether the patient had moved or appeared to have remained immobile for an extended period unless there was a particular concern which there was not in Sebastian's case. The observations were done in pairs and shared between the staff nurse on duty and the three support staff. However the same individuals did not carry out all the observations on any particular patient. There was therefore a lack of continuity. It was confirmed it was possible for a patient to be breathing but unconscious. Sebastian was heard to be snoring. Sebastian when found to be unresponsive at around 08:30 hours had a crush injury to his right arm. It was therefore apparent that he had been lying immobile on his arm for some extended period of time. Notwithstanding the Jury's conclusion that the procedures at the Norvic Clinic could not have prevented Sebastian's death I am nevertheless concerned that a failure to specifically check whether a patient has moved or rather remained immobile for an extended period on hourly observations (thereby indicating that perhaps they may have fallen unconscious) could in the future give rise to a preventable death and therefore there is a risk of future deaths occurring and that therefore a review may need to be undertaken of the procedure for night time hourly observations to specifically include whether a patient has moved or remained immobile for an extended period and whether a system can be devised to give better continuity of those undertaking observations of individual patients.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or 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 23 MAY 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: [redacted] [redacted] 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	**28 March 2013**