ANNEX A

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:** **1. Chief Executive of the Royal Devon & Exeter Hospital NHS Trust Wonford**
1	**CORONER** I am Dr Elizabeth Ann EARLAND, Senior Coroner, for the Exeter and Greater Devon 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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 15th February 2013 I commenced an investigation into the death of Roger Clive DUGGAN, Aged 61 years. The investigation concluded at the end of the Inquest on 5th March 2014. The conclusion of the inquest was Open Verdict: The Deceased was in a heightened anxiety state when he absconded from cubicle 8 in the Accident and Emergency Minors Department at the Royal Devon and Exeter (Wonford) Hospital at 00.47 hours 11th February 2013, after which, at some point, he entered the River Exe opposite Mill Lane. He also had ischaemic heart disease.
4	**CIRCUMSTANCES OF THE DEATH** 10/2/13 Wife had given him 2 x Diazepam approximately 2100-2130hrs and kept the packets in her handbag. He was in a very agitated state, pacing. Wife rang the crisis team who suggested they call 999, he said to his Wife "he wanted to get out and would not be back". After some considerable delay the Ambulance arrived and he was taken to A&E Minors RDE via ambulance late that night, but absconded from the department via main entrance at 0047hrs 11/2/13 and is shown on CCTV to leave the site shortly afterwards. An extensive search was carried out by Police in the area with no sightings. 12/2/13 Mr Duggan's body was located by a group of canoers in the water at a tributory to the River Exe, opposite Mill Lane Exeter, his body was recovered by joint emergency services and confirmed deceased at 1430hrs. Police happy no suspicious circumstances. Deceased's glasses were found, intact in his pocket. Wife states he always wore them and believes he took them off purposefully.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (2) Mr Duggan was brought to the Emergency Department of the Royal Devon & Exeter Hospital (Wonford) late on the evening of the 10th February 2013 in a state of heightened anxiety and agitation. Night Senior Nurse Mental Health Practitioner, [redacted] was called to assess. I received Evidence that [redacted] left the Deceased in cubicle 8 in Minors area (which was supervised) asking the staff nurse to sit with Mr Duggan while he spoke with the family. He was told that they would keep an eye on Mr Duggan. No one saw Mr Duggan leave the cubicle until the CCTV picked up his exit from the unit at 00.47 hours on 11th February 2013. It appears from Evidence that neither the Senior Nurse Mental Health Practitioner not night staff on the unit took responsibility for watching Mr Duggan. Mr Duggan was found Deceased in the River Exe at 14.30 hours 12th February 2013.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent further absconsions of vulnerable psychiatric patients from the hospital. This would appear to involve a clear delineation of where responsibility for the observation of these patients in the Minor area vis à vis the regular night staff and Visiting Mental Health Practitioners called to assess the patients in psychiatric emergencies.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 2nd June 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] the Deceased's next of kin. I have also sent it to Mr Duggan's General Practitioner, [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	**Inquest Date: 5th March 2014. Date of Report: 7th April 2014.** **……** Dr Elizabeth A Earland MB.Ch.B.,D.A.,Dip.Law,L.P.C,Hon.LLD HM Senior Coroner