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. **Medical Director of the Leeds Teaching Hospitals NHS Trust, St James's University Hospital, Trust Headquarters, Beckett Street, Leeds, LS9 7TF**
1	**CORONER** I am DAVID HINCHLIFF, senior coroner, for the coroner area of West Yorkshire (Eastern Area)
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 the 8th November 2011 I commenced an investigation into the death of Mary WANYA, then aged 40. The investigation concluded at the end of the inquest on 8th April 2014. The conclusion of the inquest was a Narrative, a copy of which is attached.
4	**CIRCUMSTANCES OF THE DEATH** 1. Mary Wanya was a married lady aged 40 who was born in the Democratic Republic of Congo. In or around 1999 Mrs Wanya moved to the United Kingdom. 2. At 10.48am on the 30th October 2011 she was admitted to St James's University Hospital for assessment due to her exhibiting unusual signs and behaviour. Upon admission Mrs Wanya was noted to be confused and suffering from auditory hallucinations. She gave no prior history of mental illness and was duly transferred from the Emergency Department to the Medical Admissions Unit – Ward 26 for a mental health review. 3. Ward 26 is situated on the third floor of the Chancellor Wing. 4. A diagnosis was made of stress induced tachycardia and anxiety. 5. At approximately 7.20pm Mrs Wanya was discharged from hospital. 6. At 3.05pm the following day, namely the 31st October 2011, Mrs Wanya re-presented to the Emergency Department at St James's University Hospital in an acute confusional state and appeared to be hallucinating. She tried to leave the Department on three occasions. 7. She was transferred to Ward 26. At At around 1.30am she was allocated a bed in Bay 3. 8. At 3am on 1st November 2011, Mrs Wanya was assessed. She was noted to be in a confused state, but, according to her medical records, did not show any signs of suicidal ideation and denied any acts of self harm. 9. Mrs Wanya was diagnosed with acute confusion, the underlying cause of which was unclear. 10. At 9.30am Mrs Wanya is said to have appeared less confused; there being no

indication of suicidal intent.

11. Subsequently, at around 12 noon she is seen wandering around her bed. There is a reference to her being in low mood and with some suspicious feelings.
12. A patient named [redacted] states that just before lunchtime she saw Mrs Wanya get out of her bed, walk over towards the windows located in Bay 3, all of which were closed and attempt to open both the middle and the right hand window. She failed so to do. According to [redacted] Mrs Wanya was witnessed by Nursing staff, who duly returned her back to bed.
13. At 5.30pm Mrs Wanya became restless and had physical contact with a patient in a nearby bed. Hospital security staff were called to the Ward.
14. Half an hour later, at around 6pm Mrs Wanya became very agitated and was walking around the Ward and was crawling on the floor under other patients' beds.
15. [redacted] a Staff Nurse on Ward 26, stated that she commenced duty at 7.30pm on 1st November 2011. At around 11pm she was alerted to the fact that Mrs Wanya was out of her bed and was wandering over to the left side of the middle window. Staff Nurse [redacted] and Staff Nurse [redacted] escorted Mrs Wanya back to her bed.
16. Minutes later, Mrs Wanya got out of bed and went over to the windows. She opened the far right window to an extent that enabled her to proceed through the window and fall to the ground, thereby sustaining fatal injuries, from which she died.
17. Mrs Wanya's death was certified at 11.38pm on the 1st November 2011 at St James's University Hospital, Leeds.
18. HM Inspector of Health and Safety prepared a Report for this Inquest which disclosed that the window restrictor was defective, thereby allowing the window through which Mrs Wanya allowed herself to fall to be fully opened.

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. (i) There was a considerable delay of over 60 hours before a psychiatrist attended St James's University Hospital to assess Mary Wanya. In fact the psychiatrist arrived 5 minutes after her fall had occurred and hence she never received a psychiatric assessment.
(ii) The Trust should review the system for obtaining urgent psychiatric assessments, particularly out of hours, with a view to speeding up and providing a more efficient service.
(iii) In view of the size and scale of the St James's University site the Trust should consider having an on site resident liaison psychiatrist to avoid the obvious delay in bringing psychiatrists from St Mary's Hospital, which is some distance away and will exacerbate delay.
(iv) The Trust should consider making arrangements with the Mental Health Trust responsible for the Becklin Centre so that the Becklin Centre staff should be involved with such patients, particularly out of hours, to avoid delay and to provide earlier diagnosis and treatment. Had Mrs Wanya been transferred to the Becklin Centre and been psychiatrically assessed and her treatment had commenced much earlier, it is likely that this death could have been avoided.
(v) There is an inferior system for the assessment and treatment of patients on the Medical Admissions Unit of patients suffering from mental illness in comparison with those who are physically ill. The Trust should therefore review this urgently and ensure that the systems are developed to provide for a faster system to rule out physical illness that might cause or contribute to mental disturbance and when this has been achieved to provide a prompt assessment, diagnosis and treatment for such patients in respect of their obvious mental illness.

	(2) Regarding the Trusts Level 3 Investigation Report prepared by [redacted] Head of Health and Safety dated 8th February 2012. I regard this as being an inadequate and unhelpful Report, which only concentrated on the defective windows, which although a relevant issue, this Report did not address the serious issues in respect of Mary Wanya's misdiagnosis and her inappropriate discharge from Ward 26 on 30th October 2011. The Report did not address the delays in ruling out physical illness outlined herein and the subsequent delays in obtaining psychiatric assessment. I therefore recommend that the Trust should review it's procedures for the instigation of such Reports and should ensure that the Lead Investigator and the author of such Reports has the appropriate knowledge, experience and qualifications to address the relevant issues. It is clear to me that a person from a Health and Safety background, such as [redacted] did not have the appropriate knowledge, experience and qualifications to assess medical and clinical issues, which was clearly part of the Root cause of this enquiry
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 25th 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] Messrs Lester Morrill, Solicitors, 27 Park Square West, Leeds, LS1 2PL representing [redacted] (the deceased's husband). 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	**30th April 2014** **DAVID HINCHLIFF** **Senior Coroner**