ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive Devon Partnership NHS Trust for the attention of the Clinical Director**
1	**CORONER** I am Dr Elizabeth Ann Earland, Senior Coroner for the Exeter and Great 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.
3	**INVESTIGATION and INQUEST** On8th February 2011 I commenced an investigation into the death of Elaine JOBE, date of birth 30th August 1957 (Aged 53 years). The investigation concluded at the end of the inquest on 9th June 2014. The conclusion of the inquest was a Narrative Verdict - The deceased suffered from agitated depression when as an informal voluntary patient she was admitted to Ocean View North Devon District Hospital on 18.01.2011 for treatment. She was assessed and kept on a general level of observation, hourly, by undesignated ward staff after returning from a home visit where family expressed concern over her suicidal ideation. Between 08.45hrs and 09.00hrs on 2nd February 2011 she hanged herself in Room 20 where it was not possible to see inside the bathroom from the ward. She did so by, hitherto unseen means of a dressing gown cord attached to dumb-bells over the door. She was able to do this in part because the risk of her doing this was not appreciated and preventative measures were not put in place. Immediate resuscitation and transfer to North Devon District Hospital failed to avert her death.
4	**CIRCUMSTANCES OF THE DEATH** Female was in-patient at Ocean View - psychiatric ward having been admitted with depression on 18/01/2011. On 02/02/11 she was seen by nurse at 08:45 hrs in bed - awake. The nurse then returned to female's room between 09:00 - 09:05 hrs to find her hanging from the en-suite bathroom door by a dressing gown cord entwined with a scarf and tied to a dumbbell at either end to stop the cord slipping back between the door and the frame. Pt had then put her neck through the cord and stepped off a chair (which was still upright on attendance by nursing staff). Nurse held her up and shouted for assistance. She was then moved to the ground - no pulse or breathing. She was in cardiac arrest at that time but responded after shock attempts and got cardiac rhythm back but no breathing. Transferred to ICU after resus attempt where she was ventilated. Cardiovascular stable. Maintain life support. No sedatives since 12noon 020211 and no other drugs that could interfere with brain stem death.

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] (1) Lack of record keeping Inadequate/lack of record keeping on the Ri O of (i) Risk Assessments and details of those persons making the assessments. (ii) Lack of information regarding the Levels of Observations and the persons *actually making* the observations. (2)Training Records of training of staff in the making of Risk Assessments and in understanding the meaning of the different Levels of Obs. and implementation of same. (3)Communication of patient status to incoming staff Communication of patient status with other members of staff and identification of a named nurse with responsibility for each patient on every shift needs to be reviewed so all staff are clear as to which patients they must monitor.
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 1st September 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 [NAMES] [and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. I have also sent it to [NAMED PERSON] who may find it useful or of interest. 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	14th July 2014	Signed ..... Dear Elizabeth A Earland MB.Ch.B., D.A.,Dip.Law,L.P.C,Hon.LLD HM Senior Coroner Room 226 County Hall Topsham Road EXETER Devon EX2 4QD