Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
29 Wood Street,
Barnet EN5 4BE

Telephone 0208 447 7680
Fax 0208 447 7689

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Department of Health Richmond House 79 Whitehall London SW1A 2NS
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater London
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 the 9th February 2012 I opened an inquest touching the death of Dale Owen Ricardo Scott Proverbs , 21 years old. The inquest concluded on the 8th December 2014. The conclusion of the inquest was "Narrative", the medical case of death was 1a Sudden adult death in a person with Schizophrenia.
4	**CIRCUMSTANCES OF THE DEATH** The narrative conclusion sets out the facts. On the 22nd January 13.30 Mr Proverbs was placed in seclusion at the North London Clinic where he was a patient detained under the Mental Health Act 1983. Mr Proverbs was, whilst in seclusion to be placed under continuous observation. Mr Proverbs was last observed at around 19.00 hrs when he spoke to a member of staff who was observing him through the seclusion room window. Mr Proverbs asked to speak to the nurse who was carrying out the period of observation and that interaction was the last time that Mr Proverbs was seen

alive. Between 15 to 20 minutes later a member of staff looking through the seclusion window noticed that Mr Proverbs was unwell and the alarm was raised. The nurse who was responsible for carrying out continuous observations was sitting on a sofa and did not have Mr Proverbs in his sight at the time that he collapsed.

An ambulance was called at 19.22 and arrived at the hospital at 19.29 and the ambulance staff reached Mr proverbs at 19.32 Hrs.

The Hospital policies in place at that time required continuous observation of a patient in seclusion and this did not happen resulting in Mr Proverbs collapse not being witnessed and as a consequence Mr Proverbs death was contributed to by neglect.

The use of Clopixol played a more than minimal or trivial contribution to Mr Proverbs death in that it is the most likely of a number of possible causes of the ventricular fibrillation.
(End of narrative conclusion)

Care at the North London Clinic was provided by Partnerships In Care.

There are 3 documents that deal with the question of observation in seclusion and these are firstly the
Code of Practice Mental Health Act 1983
Clinical Practice Guidelines – Violence The short-term management of disturbed /violent behaviour in in-patient

psychiatric settings and emergency departments. 2005/ 2006 North London Clinic Hospital Policies.-

It seems to me that the purpose of these policies is to ensure that seclusion is properly used and managed safely.

Mr Proverbs was transferred to the North London Clinic on 21st October under Section 48.

The use of seclusion was determined using Policy 94 together with other relevant policies and the code of Practice for the Mental Heath Act.

Policy 94 which is titled NURSING PATIENTS IN SECLUSION AND LONGER TERM SEGREGATION.

The introduction sets out that

Nursing patients in seclusion or in longer term segregation can be complex and require clear guidance to promote good practice within the Partnerships In Care. The policy sets out the context and framework within which Partnerships In Care staff will practice.

The policy is to be read in conjunction with

Mental Heath Code of Practice England and Wales.

Partnerships In Care operational policies – Safe and Supportive Observations

Reviewing of incidents and untoward occurrences

Guidelines for the use of rapid tranquilization

Health Record and Management

Partnerships In Care Operational Policy.

The Partnerships In Care policy where under the heading observation the following sets out:-

The aim of the observation is to monitor the condition and behaviour of the patient, specifically in relation to the reason for the seclusion and to encourage de-escalation and positive engagement as well as ensuring that the patient is safe. This level of observation is continuous.

.....the observing staff must be present at all times . they must be constantly alert to the wellbeing of the secluded patient , and record observations of the patients behaviour and evidence of risks within a maximum period of every 15 minutes.

And then this :-

Where a patient in seclusion has been sedated , a registered nurse should remain in sight and sound of the patient at all times and vital signs should be recorded at regular intervals until assessed by the nurse in charge and vital signs are normal.

	The code of Practice for Mental health 1983 sets out at para 15.55 A suitably skilled professional should be readily available within sight and sound of the seclusion room at all times throughout the period of the patients seclusion. And at 15.56 The aim of the observation is to monitor the condition and behaviour of the patient and to identify the time at which seclusion can be ended. The level of observation should be decided on an individual basis. A documented report must be made at least every 15 minutes. Towards the end of the inquest, and in response to the issues raised at the inquest, the current Partnerships In Care policies were redrafted to conform exactly with the Code of Practice for the Mental Heath Act 1983.
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. – That there were, at the time of Mr Proverbs death, Partnership In Care Policies in place that created a higher standard of observation required for patients on seclusion than the Code of

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	Practice for The Mental Heath Act 1983 prescribed. The Partnerships In Care Policies in place at the time of Mr Proverb's death , if followed, are likely to have prevented his death. If the Code of Practice for the Mental Heath Act 1983 were to be followed by Partnerships In Care, which is now their policy, then the level of observation for patients in seclusion would not be enough to prevent another fatality were the circumstances to be the same as those surrounding Mr Proverbs death.
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 Tuesday 31st February 2015. 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;- Representatives of [redacted] Partnerships in Care [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	6th January 2015