REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **West London Mental Health NHS Trust on behalf of Broadmoor Hospital**
1	**CORONER** I am Peter James Bedford, Senior Coroner, for the coroner area of Berkshire
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 4th March 2015 I concluded an Inquest into the death of Darren Linfoot, a thirty-three year old detained patient at Broadmoor Hospital. The Inquest was heard before a Jury.
4	**CIRCUMSTANCES OF THE DEATH** On the 18th December 2011 Darren Linfoot was declared deceased at Frimley Park Hospital, Surrey. He had been a patient at Broadmoor Hospital since the 17th November 2011 and he was found unresponsive in his room in the hospital by nursing staff. A post mortem examination found a cause of death of Lobar Pneumonia to which Dihydrocodeine Toxicity contributed.
5	**CORONER'S CONCERNS** During the course of the Investigation the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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) The evidence was that a variety of drugs and medications are dispensed from the hospital's in-house pharmacy for use of individual patients on the individual wards. Only controlled drugs are audited and their whereabouts monitored. Among others, Opiate drugs are classed as non-controlled and are therefore not audited. There is a real risk that potent medication could go unaccounted for and could end up in the possession of patients. (2) The evidence revealed that the methods of performing regular four hourly observations of patients by nursing staff was not fully understood and nurses have contrasting methods of how they conducted these observations. It is suggested that a consistent method is identified and appropriate training is provided. (3) Nursing staff also gave inconsistent evidence about the duties of the radio nurse on the admissions ward. There appeared to be a need for consistency and appropriate

	training.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe your organisation has 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 Wednesday 6th May 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 family of Mr Linfoot. You are 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	**9th March 2015** **Peter J. Bedford** **Senior Coroner for Berkshire**