## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

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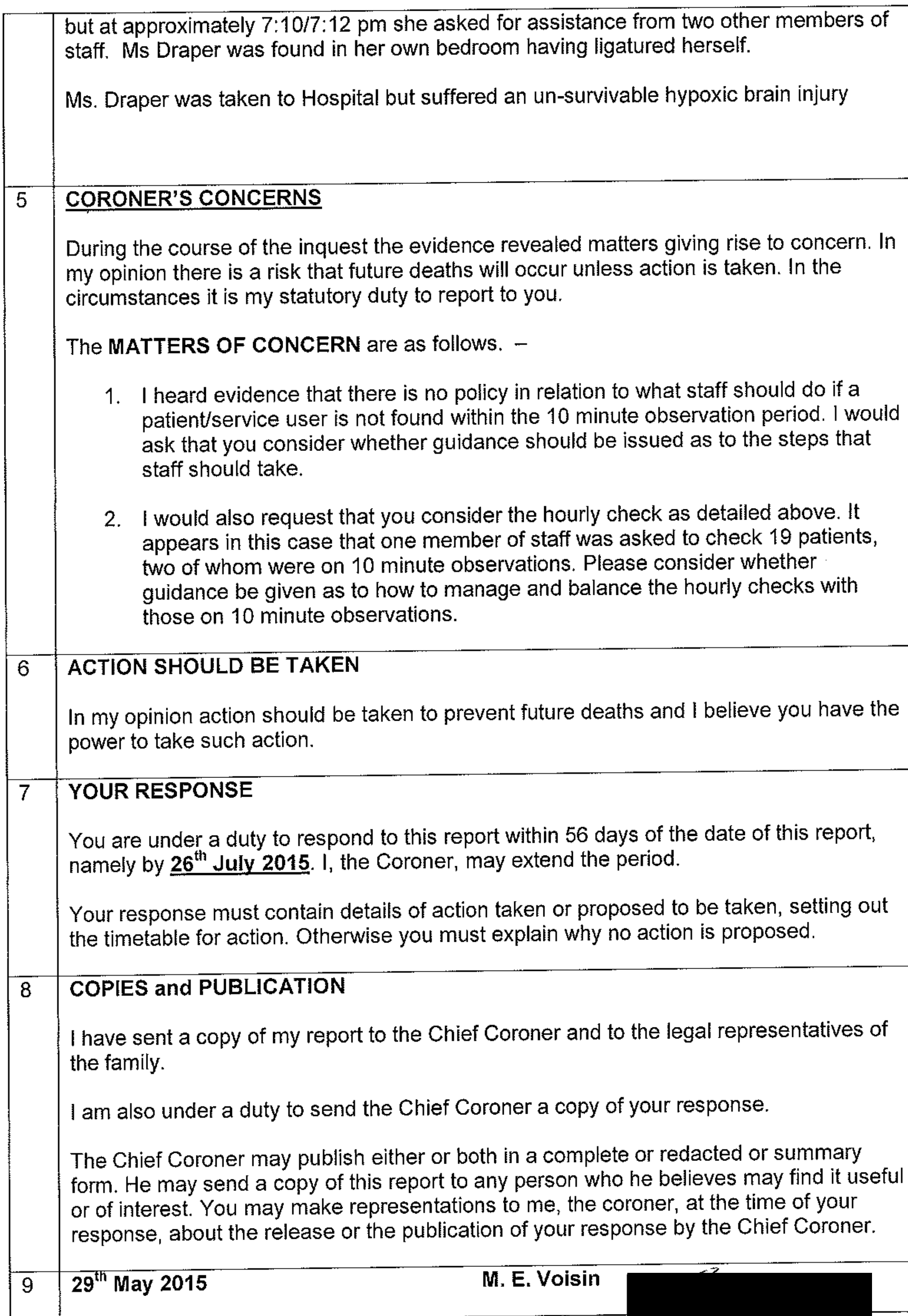
| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>1. **Iain Tulley**<br>**Chief Executive**<br>**Avon & Wiltshire NHS Partnership Trust** |
| 1 | **CORONER**<br><br>I am Maria Voisin, Senior Coroner, for the Area of Avon |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 10th September 2014 an investigation into the death of **Alison Jane DRAPER**, Aged **45** commenced. The investigation concluded at the end of the inquest on 28th May 2015. The conclusion of the inquest was:<br><br><u>Medical Cause of Death</u><br><br>Ia Hypoxic brain injury<br>Ib Neck ligature<br>Ic Mental health issues<br><br><u>Conclusion – Narrative</u><br><br>Alison Draper was found ligatured in her bedroom whilst a patient on Juniper Ward, she died from the injuries she sustained, her intention is unknown. She was on 10 minute observations at the time and should have been checked at 7pm she was not found in her bedroom until approximately 7.12pm which was 20 minutes approximately from the previous check; this resulted in a lost opportunity to render medical care, attention or treatment. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Ms. Draper had a history of mental health problems over a number years which included several attempts to self-harm and take her life.<br><br>On 8th August 2014 she was admitted to Elizabeth Casson House at Callington Road Hospital, she was detained under Section 2 of the Mental Health Act.<br><br>During this admission she made 8 attempts to take her life by ligature. The risk of self-harm/suicide was described by her Consultant. [redacted] as being chronic and impulsive.<br><br>On 5th September 2014 Ms. Draper was stepped down from the Psychiatric Intensive Care unit to Juniper Ward (an open acute unit).<br><br>On 7th September a Health Care Assistant was tasked with carrying out 10 minutes observations on Ms. Draper. She last observed her at 18:50 in the garden.<br><br>At the 7pm check the same Health Care Assistant was also tasked with carrying out the hourly checks for all 19 patients on the ward, two of whom were on 10 minute observations, one of whom was Ms. Draper.<br><br>It is unclear how the checks were actually carried out as the witness could not remember |



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| | but at approximately 7:10/7:12 pm she asked for assistance from two other members of staff. Ms Draper was found in her own bedroom having ligatured herself.<br><br>Ms. Draper was taken to Hospital but suffered an un-survivable hypoxic brain injury |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>1. I heard evidence that there is no policy in relation to what staff should do if a patient/service user is not found within the 10 minute observation period. I would ask that you consider whether guidance should be issued as to the steps that staff should take.<br><br>2. I would also request that you consider the hourly check as detailed above. It appears in this case that one member of staff was asked to check 19 patients, two of whom were on 10 minute observations. Please consider whether guidance be given as to how to manage and balance the hourly checks with those on 10 minute observations. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by **26th July 2015**. I, the Coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the legal representatives of the family.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **29th May 2015** **M. E. Voisin** |