INQUEST TOUCHING THE DEATH OF GLENDA DAY
NOTTINGHAM CORONER'S COURT

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Ms R Hawkins Chief Executive Nottinghamshire Healthcare NHS Foundation Trust Duncan MacMillan House Porchester Road Mapperley NG3 6AA
1	**CORONER** I am Heidi Connor, assistant coroner, for the coroner area of Nottinghamshire.
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 26 June 2015, I commenced an investigation into the death of Glenda Day, aged 50 (DoB 17 January 1965).The investigation concluded at the end of the inquest on 20 October 2015.The conclusion of the inquest was that her cause of death was opiate toxicity. A conclusion of suicide was recorded.
4	**CIRCUMSTANCES OF THE DEATH** Glenda Day had a history of mental health problems dating back over many years. She was admitted to ward B2 at Bassetlaw Hospital on 5 February 2015 (having initially been treated in Harrogate from 3rd February) following an overdose. On 5 March 2015, [redacted] consultant psychiatrist, advised that Glenda could have home leave. This advice was given by him over the telephone, without reviewing the patient himself. On that occasion, he did however ask for a trainee, [redacted] to see Glenda before she went home. [redacted] saw Glenda himself on 9 March, after her return from home leave. He determined that she could have a further period of home leave, and thereafter, they would consider discharging her. Glenda was re-admitted via the ED on 10 March, after taking an overdose of Quitiepine and Oromorph. Following review by [redacted] 11 March, it was recorded that Glenda did not regret her actions, and felt bad that she had not succeeded. She described having no protective factors and having ongoing suicidal thoughts, with plan. [redacted] recorded the view that Glenda was at high risk and that further home leave should be suspended until the next review.

Glenda was however given home leave the following day. The records show that she wanted to leave the ward, and the initial plan, until around 1600hrs, was that [redacted] would come and review her. There is a further record (at 1724hrs) of a telephone conversation between [redacted] and ward staff. [redacted] said that Glenda could be allowed home leave that evening. He said at the inquest hearing that he had been too busy to see Glenda that evening.

[redacted] had not seen Glenda since 9 March 2015.He told the court that he was aware of Glenda's overdose the previous day, and [redacted] note of 11 March. In her statement, [redacted] states that [redacted] did not consult the records before giving this advice.

Ward staff were concerned about Glenda going home that evening, and asked the on-call doctor to review her. She was seen by [redacted] (note recorded at 1827), who agreed that she could go on home leave. [redacted] note records that the family were concerned about her going home at that time. Glenda left after [redacted] review.

Sadly, Glenda went home and took a fatal overdose. She died on 13 March 2015.

The completion of the inquest started on 23 September 2015, and was due to finish that day. At that hearing, [redacted] told us that he felt that everything possible had been done for Glenda, and that, if he treated another patient like her, he would not do anything differently.

This concerned me greatly, as did the trust's action plan, which I felt was incomplete. I therefore adjourned the inquest part-heard, and re-listed it for 20 October 2015. At this hearing [redacted] accepted that he should not have granted Glenda home leave on 12 March 2015, by telephone, without further review, and that her risk assessment should have been updated.

I noted from her records that it appeared Glenda was always a patient who complied with medical advice. She waited to be reviewed by doctors before leaving on 12 March, although she was a voluntary patient. I found that, on the balance of probabilities, if [redacted] had refused her home leave on 12 March, she would have remained on the ward, and would not have taken the fatal overdose which caused her death on 13 March.

Glenda was of course reviewed by [redacted] before she left on 12 March. He agreed that she could have home leave. This review only took place at the request of ward staff, however, who were clearly concerned about her leaving without further assessment.

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. It would appear that [redacted] twice granted Glenda home leave by telephone, without seeing the patient himself. On the first occasion (5 March), he did ask a trainee to see her first. On the second (12 March), he appears simply to have repeated his view of 9 March (when he last saw Glenda) without seeing her first, or asking a colleague to see her, despite the significant events which had occurred between 9 and 12 March. Her risk assessment had also not been updated since her overdose on 10 March.
2. Ward B2 have addressed this and I was satisfied that current ward and medical staff are now clear that before any patient is granted home leave, he/she must have :

	a. been reviewed by a doctor ; and b. had his/her risk assessment reviewed. 3. I remain concerned however for patients across the wider trust and indeed for this ward when new staff are taken on, who may not be familiar with this tragic case. It seems to me very important to have these requirements enshrined in written policies. I understand that some work has already gone into this. 4. I was advised that a Home Leave Policy does exist for the Ward B2, but neither the ward manager [redacted] nor the most senior nurse [redacted] was able to tell me with any certainty whether these were in fact new requirements, or requirements that were already contained with the existing policy, which had been overlooked. 5. I was also concerned that the focus was very much on this ward, rather than the trust as a whole. Whilst I was advised that a trustwide review is ongoing (dealing with involuntary patients as well), no witness could tell me whether these requirements are likely to be included in a trustwide policy, and when this review will be completed. 6. I remain concerned that the focus of this investigation has been too narrow. It is clearly important that these requirements are included in the written Home Leave Policy, and communicated to all relevant staff, across the trust. 7. It is also concerning that there appears to be no timescale for the two requirements referred to above – ie how contemporary does a doctor review and risk assessment review need to be before the patient can be granted home leave ? 8. I am also concerned to know about the trust's plan in terms of staff awareness of home leave policies, across the trust, as well as auditing, to ensure that the policy is being adhered to.
6	**ACTION SHOULD BE TAKEN** 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by 18 December. 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 : Family of Glenda Day (address held by us). 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	**22 October 2015**