Regulation 28: Prevention of Future Deaths report

Brenda Elizabeth MORRIS (died 20.07.15)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Medical Director** **East London NHS Foundation Trust** **Trust Headquarters** **9 Alie Street** **London E1 8DE**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 22 July 2015 I commenced an investigation into the death of Brenda Elizabeth Morris, aged 66 years. The investigation concluded at the end of the inquest yesterday. I made a determination of suicide, when Ms Morris drowned herself in the bath at home.
4	**CIRCUMSTANCES OF THE DEATH** Approximately three weeks before she died, Ms Morris took an excess of Oramorph and was taken to hospital. She then went to see her general practitioner, who was extremely concerned and arranged for immediate referral to the mental health services. Ms Morris was admitted to Larch Lodge, where she was treated as an informal patient. She was given weekend leave in mid July and again on Sunday, 19 July, the day before she died.

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. Brenda Morris was allowed weekend leave on the basis that her partner was at home to keep an eye on her, but no member of staff told him this. This was not a situation where she needed 24 hour supervision Nevertheless, it would have been helpful for him to know the basis for the leave, because he would then have modified his own behaviour accordingly. 2. The weekend before the weekend of her death, Ms Morris's partner felt that she had not been well during the weekend leave. I appreciate that care must be taken not to override a patient's autonomy, but it might be useful for staff routinely to consider whether they are able to obtain feedback from family members after such leave. 3. There appears to be confusion about whether a doctor is needed to authorise unplanned leave of an informal patient (not relevant in this case because the leave had already been authorised). Your serious incident review of this matter indicates that this is necessary, but I heard evidence that such medical authorisation is not routinely sought. 4. Substandard documentation in the nursing records had already been identified before the inquest by your serious incident review. Without improvement in the records, it is not possible to determine whether and if so by whom a necessary risk assessment is undertaken, e.g. immediately before weekend leave is taken.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you and 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 16 May 2016. 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 following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • [redacted] partner of Brenda Morris 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 19.02.16