REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: **The Director of Primary Care:** Broadmoor Hospital, Crowthorne, Berkshire, RG45 7EG
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** I conducted an Inquest into the death of Mr Christopher Harold Brand that was heard at Reading Town Hall between 11th and 12th April 2016. The conclusion of the Inquest was that Mr Brand died from Natural Causes.
4.	**CIRCUMSTANCES OF THE DEATH** Mr Brand was a 53 year old patient of Broadmoor Hospital who returned there in the early hours of Monday 1st July at 2013 after undergoing treatment at Frimley Park Hospital to unsuccessfully remove the arm of a pair of spectacles from his Urethra. He had discharged himself and was placed in a seclusion room under eyesight observation. Shortly after his bedroom door was unlocked at 07.15 hours he was found to be unresponsive by nursing staff. Resuscitation attempts were made but he could not be revived.

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5. **CORONER'S CONCERNS**

During the course of the Inquest, the evidence revealed matters giving rising to concern. In my opinion there is a risk that future deaths could occur unless this action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

(1) There were periods during the observation of Mr Brand by nursing staff where the hospital observation policy was not followed correctly. In particular, one nurse gave evidence that he saw no movement from Mr Brand after 06.50 hours for some 40-50 minutes. His view of Mr Brand was obscured by poor lighting in the room, scratches to the observation window through which he was observing Mr Brand and by the positon in which Mr Brand was lying under heavy bedding. He made no effort to ensure that Mr Brand was safe and well, in line with the policy.

(2) When the door to Mr Brand's room was unlocked at 07.15 on 1st July 2015, no attempt was made to check that he was alive and well in breach of the policy at the time. At least a further 10 minutes passed before it was realised that Mr Brand had not moved and checks revealed him to be unresponsive.

(3) Having found Mr Brand to be unresponsive, nursing staff did not immediately begin CPR. The evidence shows that it was only the 4th member of staff attending Mr Brand who commenced CPR and there was a delay while the first staff on the scene called for more senior assistance.

(4) While the failure to follow hospital policy may not have directly impacted upon the circumstances of Mr Brand's death, the nature of the breaches are so fundamental that they could be the difference between life and death of a patient on future occasions.

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 17 June 2016. I, the Coroner, may extend the period.

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	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 Brand. 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.	**21st April 2016** **Peter J. Bedford** **Senior Coroner for Berkshire**