Regulation 28: Prevention of Future Deaths report

	THIS REPORT IS BEING SENT TO: Chief Executive, Coventry & Warwickshire Partnership NHS Trust
1	**CORONER** I am Bina Patel, Assistant Coroner for the area of Coventry.
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 the 7th day of June 2016 my Senior Coroner, Sean McGovern, commenced an investigation into the death of John James Leo Scallan. I concluded the investigation by way of a two day inquest on the 1st day of November 2017. The medical cause of death was 1a Respiratory depression from sedative drugs codeine, morphine and zopiclone. My Conclusion was a narrative: *Mr Scallan was prescribed the drugs found in his body post-mortem but the levels of codeine, morphine and zopiclone exceeded those actually prescribed*.
4	**CIRCUMSTANCES OF THE DEATH** Mr Scallan was admitted to University Hospital Coventry & Warwickshire on the 24th day of May 2016 after sustaining injuries as a result of an alleged assault. During his admission he underwent an operation to fix a fracture of the mandible.

	On the 27th May 2016 following an outburst on the ward Mr Scallan left the ward and on his return and on the advice of a Consultant Psychiatrist, he was transferred to the Hearsall Ward at the Caludon Centre on the 28th May 2016 as an informal patient where he was placed on Level 2 – intermittent observations otherwise known as 15 minute observations. On the 29th May 2016 at 12:25 hours in his bedroom at the Caludon Centre, he was found to be unresponsive following a cardiac arrest. During his admissions he was prescribed and administered drugs; however, the levels found in his blood after death were in excess to that prescribed. There was no explanation as to how this occurred. No concerns regarding his condition had been raised by those observing him.
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. During the inquest the court heard evidence from [redacted], Consultant Physician and Clinical Pharmacologist. He highlighted the inconsistences in the observation chart from Hearsall ward and the statements from the staff that compiled it. The Observation Chart also implied protocol that required staff to enter the room of patients who had not moved since the last check i.e. "that if the patient is asleep and not moved since the last check welfare is assessed and recorded". There was no record of this having happened, despite runs of readings by different observers that indicated Mr Scallan was in the same position on consecutive observations. Professor Ferner's evidence was that the observations undertaken would not have sufficed to detect deterioration in the clinical state of a patient who was poisoned with sedative drugs. The NHS Coventry & Warwickshire Partnership Trust Observation and Engagement Policy states the checks should be seen in terms of positive engagement with the patient and involve, whenever possible, interaction and positive contact with the patient.

	The **MATTERS OF CONCERN** are as follows: 1. 1. The adequacy and reliability of the intermittent observations. 2. 2. The Observation and Engagement Policy indicates checks should be seen in terms of positive engagement with the patient and involve, whenever possible, interaction and positive contact with the patient and sighting the patient from a distance and recording whereabouts is not acceptable intermittent observation. The evidence from the front-line health care assistants showed little insight into the requirements of intermittent observations as well as awareness of the new observation sheets and how these should be completed in line with the policy. There was a clear reluctance by members of staff to enter a patient's room to conduct observations in particular, when the patient was sleeping in the middle of the day.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that 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 **8th January 2018**. 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. • the Chief Coroner of England & Wales • [redacted], Father of John James Leo Scallan 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	13th November 2017  **Bina Patel** **Assistant Coroner for the area of Coventry**