M. E. Voisin
Her Majesty's Senior Coroner
Area of Avon

21st May 2018 REF: 2223

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] – **Deputy Clinical Director** **Bristol Community Health** **South Plaza** **Marlborough Street** **Bristol** **BS1 3NX**
1	**CORONER** I am M E Voisin Senior Coroner for **Area of Avon**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 13/07/2016 I commenced an investigation into the death of Michalla Jane SWEETING. The investigation concluded at the end of the inquest. The medical cause of death was: 1a) Aspiration of gastric content in association with methadone toxicity The conclusion of the jury inquest was a narrative which read as follows: "Michalla's death was contributed to by inadequate carrying out and response to prison officer ACCT checks, unsatisfactory handover quality between shifts, inappropriate process of assessment at the medicine dispense hatch and inadequate communication between healthcare and prison staff. There was neglect due to a combination of the following gross failures: • Nurse to act on handover by HCA as noted on systm one 1st June 2016 at 14.50 by physically assessing Michalla and making a plan and by still administering Methadone at 17.56 • Nurse failed to check and update Michalla's records and contact a doctor and formulate a care plan after witnessing Michalla being sick at 22.14 1st June 2016 • Nurse performed woefully inadequate clinical observations from 1st June 2016 at 22.14 onwards, including 2nd June 2016 at 03.21"

4	**CIRCUMSTANCES OF THE DEATH** Deceased was a remand prisoner. She was undergoing a detoxification programme and was on an ACCT. There were concerns raised by a number of people including a healthcare assistant that she was over sedated and this was reported to 2 nurses, Michalla was not physically assessed and she was still given her Methadone after this concern was raised. It appears unlikely that Michalla's over sedated appearance was handed over from the day to the night clinical staff. Later that day she was seen by Nurse Mark Smith who saw Michalla unwell in her cell, he did not check her records which included a reference to her being over sedated that day; he did not put his entry in the records until after Michalla's death; he did not carry out observations or make a plan and the one observation he did carry out at 03.21hrs on 2nd June 2016 was described as woefully inadequate by the expert. Sadly Michalla was found unresponsive in her cell at 07.00hrs on 2nd June 2016. Her cause of death is described above
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. – For Bristol Community Health: 1. Handover: a. That the handover includes all prisoners/patients undergoing detoxification. b. That the handover is the responsibility of the registered nurse c. That it includes a review of the records for the shift by that registered nurse – this was raised by [redacted] and was reflected in the jury conclusion. I therefore report this to you for your consideration in preventing future deaths 2. Observations for prisoners/patients undergoing detoxification: that they are taken at a time which is close to the time of dispensing medications so that the staff administering the medication have that information. Again this was raised by [redacted] as being the best time to review the observations and was indeed reflected in the jury conclusion.

Telephone 01275 461920
Email AvonCoronersTeam@bristol.gov.uk Website www.avon-coroner.com
The Coroner's Court, Old Weston Road, Flax Bourton, BS48 1UL

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 17th July 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 Chief Coroner and to the following interested persons – Family, HMP Eastwood Park, Avon & Wiltshire Mental Health NHS Trust, [redacted] 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	21/05/2018 Signature_____ M E Voisin Senior Coroner **Area of Avon**

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