REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) The South London and Maudsley NHS Foundation Trust ("SLAM")** **(2) The Care Quality Commission**
1	**CORONER** I am **HENRIETTA HILL QC**, Assistant Coroner, for the coroner area of Inner South District of Greater London.
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** **WILLIAM DICKENS**, then aged 77 years, died on 10 May 2017. An investigation into his death was opened and an inquest held from 1-4 and 8 May 2017. The medical cause of Mr Dickens' death was hanging. The jury returned a narrative conclusion identifying a range of issues which they concluded had contributed to Mr Dickens' death.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows: (1) Until late April 2017 Mr Dickens had no issues with his mental health. His family noticed a deterioration in his mental health at that point and he was prescribed medication by his GP. (2) On 9 May 2017 Mr Dickens tried to take his own life at his home by wrapping a telephone cable around his neck. An ambulance was called and he was taken to St Thomas' Hospital. When there he was classified as at "high" risk of repeat self-harm and kept on one to one observations. (3) He was transferred to the mental health unit for older patients at the Maudsley Hospital, run by SLAM. On arrival there he was again classified as at "high" risk of repeat self-harm.

	(4) Mr Dickens was placed on a regime of intermittent observations which meant he should be seen at varying intervals but at least every 15 minutes. (5) His property was searched and in breach of SLAM policy and recognised process his belt was returned to him. (6) Despite being on a regime of intermittent observations, Mr Dickens was not seen from 9.47 am until he was discovered hanging by a belt from the bed in his room just before 10.40 am.
	CORONER'S CONCERNS During the course of the inquest the evidence revealed matters giving rise to concern, and I continue to consider that such matters exist. 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 that: (1) From 10 am on the morning of 10 May 2017 the observation regime for the ward was not complied with. While there are notes on the observation log suggesting that some patients had been seen in the period between 10 am and 11 am, Mr Dickens was not seen from 9.47 am until he was discovered hanging by a belt from the bed in his room just before 10.40 am. The observation log shows that several other patients were unaccounted for during the same period. (2) During the inquest the nurse in charge of the ward gave evidence that the entries she had made on the observation log for the period between 10 am and 11 am were not made contemporaneously but after Mr Dickens had died. No note had been made on the log to indicate that the entries were being made after the event. (3) While the observation log may have different purposes, it seems to me that two reasonable purposes of it are (i) to act as a prompt to make sure that the necessary checks on the patients were in fact conducted; and (ii) to ensure that there is a record that at a certain time, certain patients had been accounted for and were safe. (4) Those purposes are plainly frustrated if entries are made on the log at times that are different to the actual observations, and after the event. (5) Given that part of the purpose of the log is to ensure the safety of patients, particularly those such as Mr Dickens who are at high risk of self-harm or suicide, defects in the observation log process give rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future.
6	**ACTION SHOULD BE TAKEN**

	I consider that action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances. Accordingly, I am reporting the matter to you as I believe you may 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 4 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 the family of Mr Dickens who were an Interested Person in the inquest. 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	**Signed** *.....Henrietta Hill QC*..... **Assistant Coroner**