	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], Chair of Fitness to Practice, Nursing and Midwifery Council, 1st Floor, 1 Kemble Street, London WC2B 4AN 2. Mr Neil Lloyd CEO, NHS Professionals Ltd, Suites 1A & 1B, Breakspear Park, Breakspear Way, Hemel Hempstead, HP2 4TZ
1	**CORONER** I am Andrew Harris, Senior Coroner, London Inner South jurisdiction
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INQUEST** I opened an inquest into the death of Mr Alex Blake, who died on 24th June 2018 in Lambeth Hospital (01761-2018). An investigation and inquest was opened on 29th June 2018 and was concluded on 27th June 2019. A jury was summoned. The medical cause of death was: 1a Heroin Toxicity
4	**CIRCUMSTANCES OF THE DEATH** The jury concluded that he died from a self-administered heroin overdose whilst a sectioned in-patient under the care of South London & Maudsley Trust at Lambeth Hospital, sometime before 04.13 on 24.06.18. The jury concluded that there were inadequate observations conducted on the night, which meant that his death went unnoticed for several hours, due to unsuitable record sheets, ineffective observations and lack of communication between staff. There was evidence that rigor mortis had begun when he was found, based on evidence of the attending paramedic.
5	**CORONER'S CONCERNS** During the course of the inquest, the evidence revealed concerns with the implications of the evidence of three witnesses employed by NHS Professionals at

	times when the deceased was already dead. This leads me to have an opinion that there is still a risk that future deaths will occur unless action is taken with respect to these individuals. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – The first was RMN T, who gave evidence that the deceased was half out of bed, wearing pyjamas and she assumed to be asleep at 05.00. When asked whether he could have been dead, the nurse said she did not know, but it was too dark to see and no torch was used. She chose to wait until 06.00 to conduct a proper observation. She could not answer the question why she had not gone to get a torch or returned before 06.00. When found in the same position an hour later, she says she was concerned and asked Health Care assistant K if he was breathing as he had been in the same position for an hour. HCA K denies that this conversation took place before he was found dead. RMN T on finding the deceased said that it still did not occur to her that he might be dead. Her evidence to the court that he was wearing pyjamas at 05.00 is in contrast to the electronic patient journal, which confirms that when he was found dead he was topless. The second was RMN E, whose evidence was read due to his unavailability. He made an entry in the electronic journal at 05.59, which is about the time which he was found dead, that *"he went to his bedroom and was observed asleep from 23.00 hrs. Alex remains asleep and was observed breathing regularly at the time of this entry* (05.52)." The deceased was already dead at the time this entry claims to have been written. RMN T told the court that she had no communication with RMN E about his observations and RMN E was not one of those who found him dead at about 06.10 hours. This raises concern about what prompted the unusual entry at 05.59. The third was health care assistant K, whose evidence in court was that the deceased was observed at 03.00 and he held his phone in his hand which was lit up, and so assumed to be watching a film. The witness was unable to answer why he had then recorded the deceased as being asleep, as it would be likely then that the light of the phone would not be visible. The evidence of these three witnesses cannot be said to be reliable. The evidence of the two nurses would seem to go beyond that of poorly conducted observations. It would be reasonable to suspect that that either the two nurses did not perform the observations at all or that they have provided false evidence to the Trust and to the court.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths. I believe that the following organizations would wish to learn of the circumstances of this death and are in a position to mitigate or prevent future deaths: As all three are employees of NHS Professionals, the agency is informed of this evidence so that they might

	consider whether to conduct an internal investigation or fitness to practice investigations and additionally consider whether there are wider implications for their recruitment and training processes. Given the serious professional and legal implications of the evidence of the nurses each is referred to the Nursing & Midwifery Council. Their identities are communicated separately and confidentially.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Wednesday 25th September 2019. 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. If you require any further information or assistance about the case, please contact the case officer, [redacted]
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following Interested Persons: [redacted], Mother Dr Matthew Patrick Chief Executive, SLAM I am also sending this report to the following, who may have an interest, Secretary of State for Health, NHS England and Royal College of Psychiatrists. 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	**[DATE]** **[SIGNED BY CORONER]** **29th July 2019** **Andrew Harris, Senior Coroner**