Regulation 28: Prevention of Future Deaths report

John Frank Henry LANSDOWNE (died 19.05.13)

	THIS REPORT IS BEING SENT TO: **1. Ms Wendy Wallace** **Chief Executive** **Camden & Islington NHS Foundation Trust** **St Pancras Hospital** **4 St Pancras Way** **London NW1 0PE**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
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 22 May 2012, my assistant coroner, Selena Ruth Lynch, commenced an investigation into the death of John Frank Henry Lansdowne, aged 62. The investigation concluded at the end of the inquest on 22 October 2013. The jury returned a narrative conclusion, which I have attached.
4	**CIRCUMSTANCES OF THE DEATH** John Lansdowne was diagnosed with schizophrenia in 1980. He had been cared for by local psychiatric in patient and out patient services for at least eighteen years prior to his death.

	On Tuesday, 15 May 2012, he was admitted to St Pancras Hospital under s3 of the Mental Health Act, at the time talking a great deal about taking his life. He had in 2010 and 2011 jumped in front of trains, sustaining very significant injuries on each occasion. At 10.30pm on Friday, 18 May 2012, he was found submerged in the bath. Cardiopulmonary resuscitation was attempted and he was taken by ambulance to University College Hospital, but he died shortly thereafter.
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. 1. The jury found that the times observations of Mr Lansdowne took place in the 45 minutes preceding his discovery were unclear, despite a nursing observation record setting these out. 2. There was confusion regarding the retrieval of the entirety of the medical/nursing records after Mr Lansdowne's death, and one observation sheet was never recovered. 3. At inquest, there was a lack of consistency in the understanding of nursing staff on Laffan Ward at St Pancras Hospital, as to the exact requirements of intermittent observations when a patient is bathing. 4. Mr Lansdowne died in the bath, it is possible as a result of drowning. Mr Lansdowne's family explained at inquest that in other hospitals where he had been treated, only walk in showers are used.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and Camden & Islington NHS Trust 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 18 December 2013. 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. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • [redacted], John Lansdowne's parents 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 23.10.13