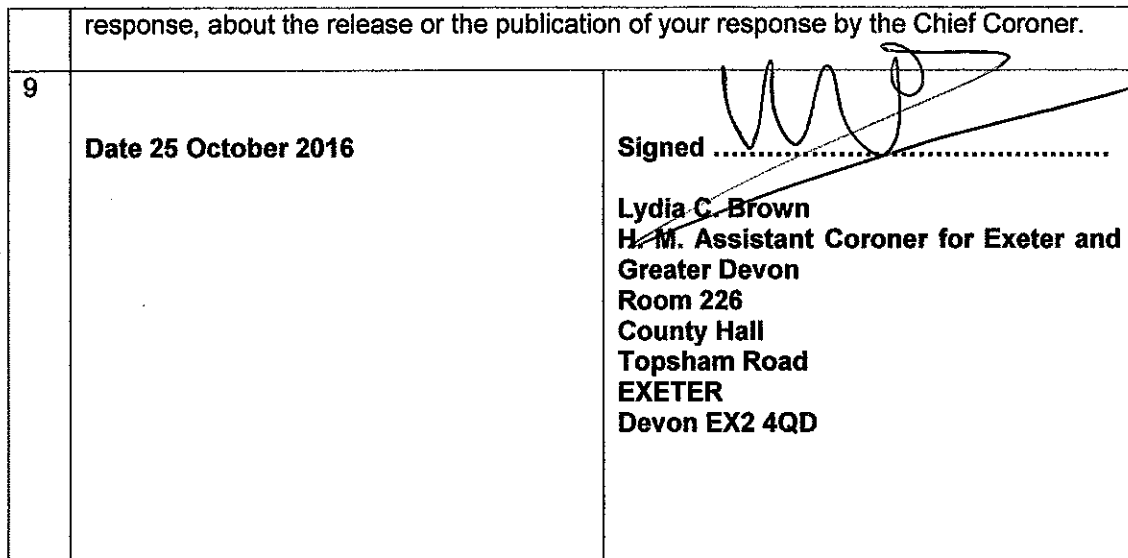
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Melanie Walker, The Chief Executive, Devon Partnership Trust Wonford House Hospital Dryden Road Wonford Exeter Devon EX2 5AF**
1	**CORONER** I am Mrs Lydia Brown, Assistant Coroner for the Exeter and Great Devon District
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** On 17th March 2015 I commenced an investigation into the death of Matthew Llewellyn-Jones. The investigation concluded at the end of the inquest on 13 October 2016. The conclusion of the jury was Medical cause of death Hanging Conclusion – suicide and narrative • We find that there was insufficient assessment of Matthew's risk of self-harm and going AWOL at both the initial assessment meeting on 15th March and the ongoing assessment meeting on the 16th March, due to inadequate notice being taken of information available from family and other 3rd parties. • We find that the level of contact received by Matthew, clinical notes and level of observation were insufficient and inadequate. • We find no evidence of use of a sign on the door to say that it was locked and that Matthew's ability to exit the door was a failure of the locked door policy. • We find that patients going through the locked door into an unsecured area to smoke increased the risk that the locked door policy would fail, and we find no evidence that the Trust took all reasonable steps to reduce that risk. • We find that the Bank Nurse did not receive adequate induction to the ward or written/oral guidance as to individual patient risks. • We find that inadequate staffing levels was a contributory factor to failings at all stages of Matthew's care and security.

4	**CIRCUMSTANCES OF THE DEATH** Matthew had a history of mental health issues and these had been managed in the community and with the care of his family. He became suddenly very unwell with psychosis and following mental health assessment was detained under s2 of the Mental Health Act for his own safety and the safety of others. The following day he was able to leave the locked ward where he was detained unaccompanied. His body was discovered over an hour later, hanging by a ligature in the grounds of the hospital.
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 Devon Partnership trust acknowledged in inquest that the "locked door" is still being breached on occasion, as identified on audit. An electronic pad or sign has been considered to offer clearer indications of when the door should be secured, but not yet trialled or actioned. The door therefore remains an ongoing security risk for the ward. (2)Observations when carried out in the context of a secure mental health environment should not be predictable or entirely regular. This is not currently part of the ward policy, although it appeared to be accepted by senior staff at inquest. The Trust should consider further measures to ensure that training and instruction given to all staff in relation to observations is clear, constantly reinforced, and in line with best practise. (3) A new system of note recording has been introduced since this death, but it still does not make obtaining information from carers and/or family mandatory on admission. The importance of this information was readily acknowledged by the Trust in their internal inquiry and at inquest. The electronic recording system should be able to facilitate capturing such information with the use of mandatory fields to avoid this oversight and could assist the Trust in achieving their stated aims in this respect.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 23 December 2016. 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. The family of Matthew The Care Quality Commission 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 25 October 2016**	**Signed ....** **Lydia C. Brown** **H. M. Assistant Coroner for Exeter and Greater Devon** **Room 226** **County Hall** **Topsham Road** **EXETER** **Devon EX2 4QD**