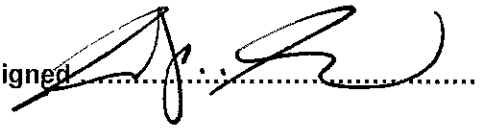
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive of the Devon Partnership NHS Trust to bring to her attention the following matters that have arisen as a result of the Evidence heard in Court.**
1	**CORONER** I am Dr Elizabeth Ann Earland, Senior 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 13th July 2012 I commenced an investigation into the death of Polly Elisabeth Jane CARPENTER, Aged 36. The investigation concluded at the end of the inquest on 13th October 2014. The conclusion of the inquest was a Narrative Conclusion : 1. Polly Carpenter took her own life on 5th May 2011. 2. She went to the railway line at Ford Bridge one and a half miles from Chard Junction. 3. Between (1:50 pm) and (1:55 pm) she calmly and deliberately sat down, in the "4 foot" between the rails in the knowledge that the Exeter bound diesel locomotive L159 approached (at 85 miles per hour). She had taken alcohol. Death was instantaneous. 4. She was suffering from emotionally unstable personality disorder when she absconded from the Cedars Inpatient Open Psychiatric Unit in Exeter, whilst formally detained under Section 3 of the Mental Health Act 1983. 5. She did so after 09.41 hours on the 5th May 2011. She left via a window in (GF113), or (GF121). 6. An inherent weakness in the security of the windows on the Unit was identified in March 2009. They were not inspected daily. 7. In the days leading up to her death, she suffered increasing intensity of emotions and frustration as she worried about her health and the welfare of her children in the care of her father in the face of her own inability to care for them. 8. On the 3rd May 2011 she exited the Unit and was found in the grounds in the morning. Later on she tried to tamper with the window of bedroom (GF113). The damage to the window was immediately reported. 9. She was given the antianxiety drug Lorazepam on 3rd May 2011. She was helped in a referral on 4th May 2011 to the Multiagency Safeguarding hub. 10. She was on Level 1 observations and the door of the Ward was locked. 11. Later on 4th May 2011 she superficially self-harmed. 12. She was not/observed at 11:00 hours on the 5th May 2011. 13. She was found to missing from the Unit at 11.00 hours. A report to the Police was recorded at 11:37 hours on 5th May 2011. 14. She absconded in part because the continuing risk of her absconding on 5th May 2011 was not appreciated and appropriate precautions were not put in place.
4	**CIRCUMSTANCES OF THE DEATH** Past Medical History - Long history of psychotic depression with repeated attempts to take her own life with several admissions to inpatient psychiatric units. Prescribed medication - Venlafaxine, Zopiclone, Diazepam, Ocanzapine. She was admitted to The Cedars Unit, Wonford House Hospital, Exeter, early in 2011.

	She was reported missing to the Police at 1137 hours on 5/5/11. The next sighting of her was at 1355 hours that same day at the railway line at Ford Bridge, approximately 1 1/2 miles from Chard Junction, Chard. A train driver reported that she appeared to deliberately step onto the track and sit down between the rails with her back facing the oncoming train. The train was travelling at approximately 85 mph when he struck the female. Police and Paramedics attended the scene. Her death was recognised at 1430 hours. Property in the name of Polly Carpenter was recovered at the scene. A post-mortem examination was carried out on 9/5/11 at Yeovil District Hospital. A sample of her blood was retained for toxicological analysis. An Inquest was opened with evidence of identification and adjourned by the Coroner for East Somerset. The jurisdiction for the Inquest was transferred to the Coroner for Exeter and Greater Devon.
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 Evidence of Named Nurse system which was in operation at the time of Polly's death indicated its execution to be somewhat nebulous. I am encouraged by [redacted] Evidence that the Trust has taken up the challenge and instituted new steps with 1:1 time and the placement of a ward board with names of nurses allocated to each patient so improving patient's access to them. (2) The reduction in AWOLS (absences without leave) is good evidence, that the two pronged approach of ++ engagement with patients on a clinical level and the decision to change the windows out to improve security is working. (3) While I note that Risks Assessments were dynamic and said to be performed regularly there was no written record of them appearing on the RIO and staff appeared to have very little or no knowledge of the levels of risk at the instant in time. (4) The decision not to formally record levels of observations and nurse allocation to do them on the RIO record remains a cause for concern. From the Evidence heard it is quite clear there can be no audit of a system which is not routinely recorded and some participants remain worryingly vague about the tasks they may/may not have performed. This does not support the view that being in hospital means that a regular robust system of care and attention is given to patients who desperately need the help for which they have been admitted. It is hoped that provision of a permanent record, would allow a culture of individual responsibility to flourish in the minds of all the nursing staff, so patients are looked after in the fullest sense of the word.
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 23rd December 2014. 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. 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	**28th October 2014.**	**Signed**  **Dr Elizabeth A Earland MB.Ch.B., D.A.,Dip.Law,L.P.C,Hon.LLD** **HM Senior Coroner** **Room 226** **County Hall** **Topsham Road** **EXETER** **Devon EX2 4QD**