	REGULATION 28 REPORT ON ACTION TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive of the Northamptonshire NHS Partnership Trust** **2. Berrywood Hospital**
1 2	**CORONER** **I am Belinda Cheney, Assistant Coroner for Northampton.** **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** I conducted three inquests into deaths that occurred in Berrywood Hospital and in two of them the concerns were similar so I have written this report to cover both deaths. On Wednesday 4th September 2013 I commenced an investigation into the death of **Jane Marie Clark** whose date of birth was 20th July.1989 The investigation concluded at the end of the inquest on 20th January 2015. The conclusion of the inquest was The medical cause of death was: 1a hanging The narrative conclusion was: **Jane Marie Clark** was an informal patient at Berrywood Hospital Northampton diagnosed with emotionally unstable personality disorder. On 22nd August 2013 staff became aware that Jane had been involved in discussions about suicide with other patients. At 07.00 hours she was found in possession of a ligature. Around 09.30 hours she was granted leave from the ward without an adequate assessment of the risks. She went to the woods and tied a ligature, intending to commit suicide. She was found deceased by a passerby at 13.40 hours. Life was finally pronounced extinct at 14.32 hours. On Wednesday 28th August 2013 I commenced an investigation into the death of **Isobel Griffin** whose date of birth was 6th September 1956. The investigation concluded on 23rd January 2015. The conclusion of the inquest was: The medical cause of death 1a hypoxic brain injury b hanging

	2 psychiatric illness The conclusion was a short form with additional comment as follows Suicide – contributed to by inconsistent community care and difficulties in treating her mental disorder in the period from 2011- 2013, and lack of adequate risk assessments and a well formulated management plan on the final admission between 1 and 17 August 2013.
4	**CIRCUMSTANCES OF THE DEATH** **Jane Marie Clark** Jane Clark had a very long standing history of personality disorder and multiple lengthy inpatient admissions. There were no issues with her care in hospital but rather that a nurse granted leave without apparently reading the notes which made clear that events in the last 12 hours (including Mrs Griffin's death some days earlier on the ward, discussions between patients about suicide, to which discussions Jane was central, attempts by others to tie ligatures on the ward in the early hours of 22nd August, Jane being found in possession of a ligature on the morning of the 22nd) required a full risk assessment and prompt escalation to the multi disciplinary team before any decision was made about leave. The risk assessment documents had further not been updated. Further, no boundaries were placed on the leave. **Isobel Griffin** [redacted] had been Mrs Griffin's psychiatrist for many years. When [redacted] retired in 2011 Mrs Griffin was seen by a number of different junior doctors in the community and frequent changes were made to her medication. She had a number of admissions to the Welland Centre and her diagnosis was changed from recurrent depressive disorder to personality disorder. On 27 July Mrs Griffin was discharged from the Welland Centre against the wishes of her family. On 28 July she attempted to take her life and was readmitted to the Welland Centre and at the request of her family transferred to Berrywood Hospital Northampton from 1-17 August 2013. She was commenced on a medication free trial. She was documented as being very suicidal in the days leading to her death and from 7th August started confiding about attempts to tie ligatures which was a new development. On 17 August around 8.30 am she hanged herself from her bedroom door on the ward with a ligature made from a bathrobe cord and a sweater. Despite efforts to resuscitate her, Mrs Griffin died on 21 August at Northampton General Hospital.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless

	action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – Re Jane Marie Clark 1. The very challenging events of the previous evening and that morning do not appear to have been handed over and the nurse in charge did not read the notes before granting leave. Her risk assessment then was ill informed. It was not discussed with anyone nor properly documented. 2. She did not place any boundaries on the leave for example providing a time by which Jane was to return. 3. Risk assessment documentation generally was poor and appeared perfunctory. Re Isobel Griffin 1. Mrs Griffin was admitted on 1 August and was not allocated a key worker until 8th August. The key worker did not read the notes so was not aware of the events of the 7th. 2. The risk assessment was not updated with the events of the 7th. 3. Mrs Griffin's responsible clinician saw her on only one occasion on 14 August 2013 at which time he did not read the notes so he was unaware of events on the 7th when she handed in a belt and scissors and said she had 3-4 times tried to hang herself using a ligature. 4. A planned review of medication, diagnosis and treatment never took place despite a number of references in the notes to it from 6 August 2013. Mrs Griffin had been substantially unmedicated for most of the admission despite concerns expressed by her family. 5. On 11 August Mrs Griffin started to express thoughts to harm others. These thoughts distressed her. She did not intend to act on them but they were something new and a measure of her distress. These thoughts and their significance were not included in any risk assessment. 6. A risk assessment concluded on the 18th, the day after she had hanged herself on the ward, purports to be made with her agreement. It was evidence that risk assessment documentation is cut and pasted rather than reflecting the true circumstances. 7. The doors do not appear to be ligature proof and little was made available by way of evidence as to what measures would now be taken to minimise this risk.
	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe that 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 9th April 2015. I, the Assistant 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, namely the families of both Jane Clark and Isobel Griffin. Similarly, you are 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.
9	**DATE** **SIGNED BY ASSISTANT CORONER** **12.2.15** ***Belinda Cheney***