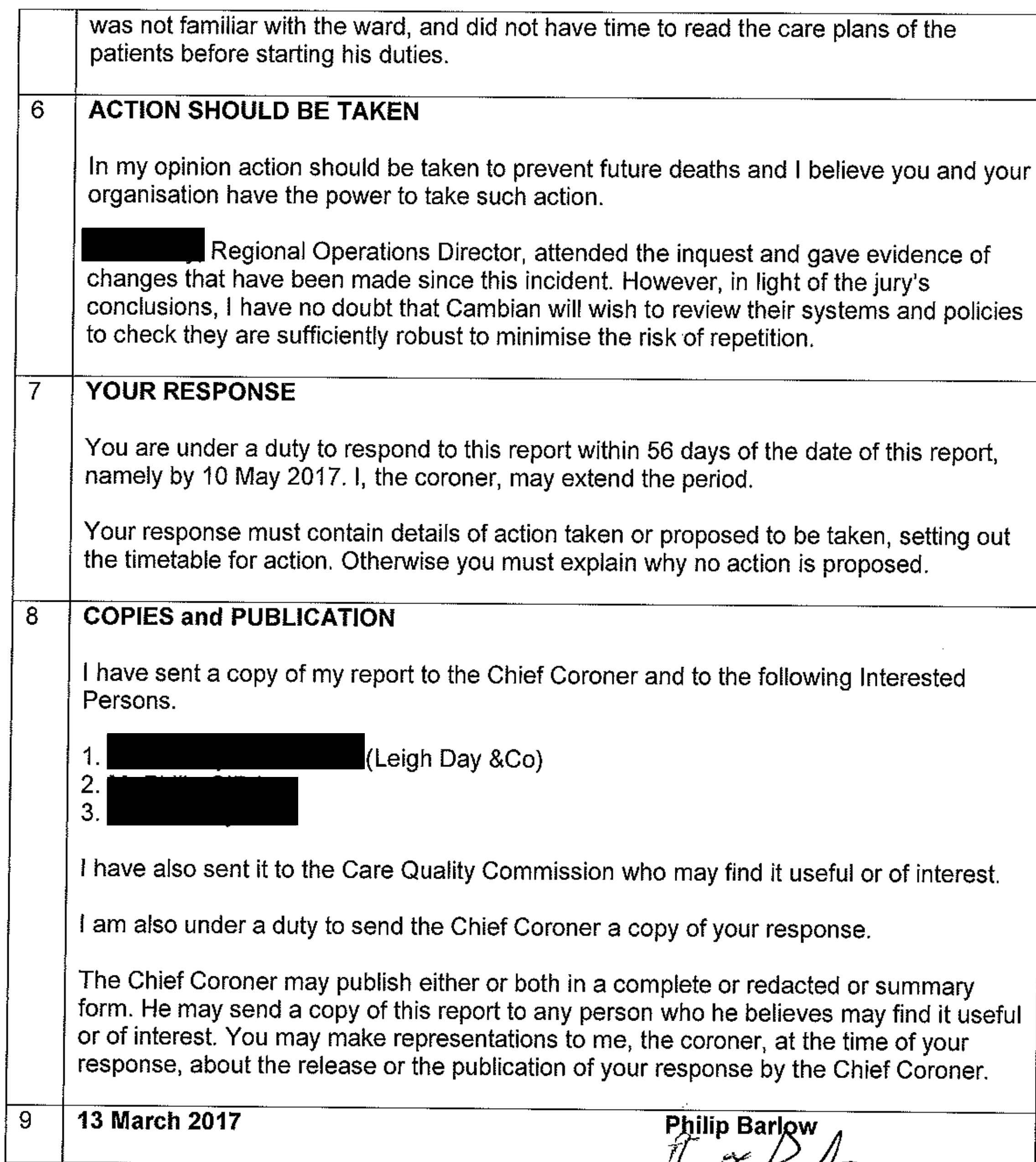
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr Saleem Asaria, Chief Executive Officer, The Cambian Group, 4th Floor, Waterfront Building, Hammersmith, Embankment, Chancellors Road, London W6 9RU**
1	**CORONER** I am Philip Barlow, assistant coroner, for the coroner area of Inner South London.
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 14 December 2015 I commenced an investigation into the death of James O'Brien, age25. The investigation concluded at the end of the inquest on 3 March 2017. The conclusion of the inquest was that Mr O'Brien died of natural causes. The medical cause of death was sudden cardiac death in schizophrenia. The jury's conclusion at the end of the inquest was that when Mr O'Brien was found to have collapsed the emergency response by hospital staff was inadequate and that earlier intervention might have made a difference.
4	**CIRCUMSTANCES OF THE DEATH** Mr O'Brien had been a patient at Churchill Hospital since March 2014 under s3 MHA. On the night of 8/9 December 2015 he was found collapsed in his room on Juniper ward. Attempts at resuscitation were made by staff and London Ambulance Service paramedics. He was taken to St Thomas' Hospital where he was died on 9 December 2015.
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) There was a failure to press the alarm. (2) There was a delay of about 4 minutes in starting resuscitation. (3) There was a delay of about 6 minutes in calling the ambulance. (4) There was a delay of about 8 minutes in bringing the defibrillator. (5) The defibrillator was not attached appropriately. (6) Inadequate information was given to the London Ambulance Service. (7) There was a failure to ensure that staff were adequately trained to respond to an emergency situation. (8) There was a failure to provide adequate induction to staff. (9) The agency nurse in charge of the ward was called shortly before the shift started,



	was not familiar with the ward, and did not have time to read the care plans of the patients before starting his duties.
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. Regional Operations Director, attended the inquest and gave evidence of changes that have been made since this incident. However, in light of the jury's conclusions, I have no doubt that Cambian will wish to review their systems and policies to check they are sufficiently robust to minimise the risk of repetition.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 10 May 2017. 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. 1. (Leigh Day &Co) 2. 3. I have also sent it to the Care Quality Commission who may find it useful or of interest. 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	**13 March 2017** **Philip Barlow**