**C.G.BUTLER**
SENIOR CORONER · BUCKINGHAMSHIRE

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. The Chief Executive, Oxford Health NHS Foundation Trust** |
| 1 | **CORONER**<br><br>I am CRISPIN GILES BUTLER, Senior Coroner, for the Coroner area of BUCKINGHAMSHIRE |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br>http://www.legislation.gov.uk/uksi/2013/1629/pdfs/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 31st December 2015 Senior Coroner Richard Alexander Hulett commenced an investigation into the death of JACK OLIVER PORTLAND, aged 29 years. The investigation concluded at the end of the inquest on 3rd February 2017. The conclusion of the inquest was set out in the Jury's narrative conclusion contained in their answers to a questionnaire. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mr Portland was a prisoner at HMP Woodhill until release at the end of a sentence on 16th October 2015. Whilst at HMP Woodhill he was diagnosed with substance-induced psychosis. Two separate ACCT documents were opened during his last period of detention at HMP Woodhill. Following release he could not be assessed at Stoke Mandeville Hospital as he was under the influence of substances and he was subsequently detained at HMP Lewes from 18th October 2015. Upon release from HMP Lewes on 4th November 2015, Mr Portland was sectioned under Section 2 of the Mental Health Act and detained at the Dene Hospital. On 4th December he was detained under Section 3 of the Mental Health Act and was transferred to the Whiteleaf Centre, Aylesbury, Buckinghamshire on 5th December 2015 where he remained a patient until his death on 27th December 2015, which occurred at Wycombe Hospital, High Wycombe whilst Mr Portland was on unescorted S17 leave from the Whiteleaf Centre. Mr Portland had been found and was attended to by paramedics at a house in High Wycombe.<br>The medical cause of death was morphine and ethanol toxicity. |
| 5 | **CORONER'S CONCERNS**<br><br>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 |

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statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

(1) The practical implementation of S17 leave involved, firstly, the grant of leave by the consultant psychiatrist and it was mandatory to provide copies of those Records of Grant not only to the patient, but also to the family of a patient along with the Inpatient clinical team and the MHA administrator. The Care Co-ordinator and GP were also optional recipients. No copies of any of Mr Portland's S17 Records of Grant of Leave appeared to have been provided to anyone other than the patient. The family were unaware of changes to leave and were unable to participate in the leave process or assist Whiteleaf with regard to any heightened risks.
(2) A specific request for leave from the patient would be actioned by a nursing-level assessment, authorisation of the specific leave by the nurse in charge and implementation of the leave by a staff member. A Record of Leave of Absence would be completed and signed by the patient and the staff member and that staff member would usually then write up that patient's name and the times out and due back on a whiteboard in the office. Evidence from witnesses confirmed that there was no particular order to the whiteboard. In the case of Mr Portland, his final leave had not been written on the whiteboard correctly and his absence was not identified until well over an hour after he was due back. The evidence indicated that the whiteboard is still used in the same way, notwithstanding that it was acknowledged that there was scope for human error and that addressing the issue was a matter of urgency.
(3) The manually-completed observation charts, forming the third element of an effective leave management process, were acknowledged to be filled out sometimes retrospectively, sometimes prospectively, sometimes by reference to the whiteboard (and evidence suggested amended later) rather than always being completed in the ward round. There was scope for human error and discrepancies between the various records of leave.
(3) The implementation of the AWOL procedure and checklist, including the application of 10-minute buffer time immediately at the end of scheduled leave was not clearly understood by witnesses in person and there appeared to be no proper overarching leave policy including proper recording of who assessed a patient prior to leave and who authorised a particular leave. There was no proper contemporaneous record of all the steps actually taken in connection of Mr Portland's AWOL.
(4) Whilst evidence from Whiteleaf indicated they were very used to receiving patients with little or no history and assessing them, the evidence in this case indicated that they had taken across the risk assessment from the Dene Hospital on transfer, that this had not been updated during Mr Portland's time at Whiteleaf and that Whiteleaf did not appear to have taken any steps to identify and procure any earlier history in relation to Mr Portland's time at HMP Woodhill. It was acknowledged in evidence that knowledge of risk of self-harm recorded in the HMP Woodhill ACCT documents would have been helpful.
(5) The actions taken in relation to the preparation of two Root Cause Analysis reports were of concern in that the first RCA was founded on inaccurate information and the second RCA still contained inaccuracies and was not completed until some 11 months after the fatal event. The ability to react quickly to issues raised and to implement new policies and working practices may have been compromised by the delays and lack of robustness of the reports. The recommendations of the second RCA indicate reviews to be conducted by February/March 2017 but do not appear to address more urgent practical action or possible staff training needs.
(6) Disclosure, initially to the Coroner, of contemporaneous interviews and information gathered during

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| | the early stages of the first RCA may have assisted in preventing subsequent delays and progressing the inquest process, enabling learning from any identified concerns to have been addressed at an earlier stage. In any event such notes and related documents did not form part of the disclosure.<br>(7) Whilst there were indications that there were changes being implemented, there was no clear indication of timescales nor did they address the particular concerns identified during this investigation. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 18th April 2017. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:<br>Messrs Leigh Day, acting for Mr Portland's family.<br>Messrs Capsticks, acting for OHNHSFT.<br><br>I have also sent it to the Care Quality Commission who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **Dated: 21st February 2017**<br><br>**Signature:.....**<br>**Senior Coroner for Buckinghamshire** |

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