ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Coventry & Warwickshire Partnership NHS Trust**
1	**CORONER** I am Jason Pegg, Assistant Coroner for the coroner area of Coventry.
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** An investigation took place into the death of Joleen Linton, aged 36 years. The investigation concluded at the end of the inquest on 24th April 2017. The conclusion of the inquest was misuse of drugs, the medical cause of death was 1(a) Drugs Toxicity (b) Drugs Abuse.

4	**CIRCUMSTANCES OF THE DEATH** Joleen Linton died on 3rd August 2016 on Spencer Ward, Caludon Centre, Coventry. Joleen Linton had been an informal patient since 14th Jury 2016. Prior to her admission to the Calydon Centre Joleen Linton had been at University Hospital Coventry & Warwickshire having been admitted following the taking of an overdose of prescribed drugs. At the time of her death Joleen Linton was subject to hourly observations to ensure that she was safe and well. The staff who conducted the observations observed patients through a small partially frosted window in the room door. Observations were undertaken in darkness with the assistance of a torch. If the patient had not moved since the last observation and was not seen to be breathing staff were expected to enter the room to check further on the patient. The position of the patient, when observed, was recorded on an observation chart. The observation chart recorded that at 0400 hours; 0500 hours and 0700 hours on the morning of 3rd August 2016 Joleen Linton was asleep on her front. At 0600 hours it was recorded that Joleen Linton was asleep on her back suggesting that she had moved and changed position at least once between the 0500 hours and 0700 hours observations. Joleen Linton was discovered deceased in bed in her room at 0800 hours on 3rd August 2016, there was rigor mortis and early signs of decay. Joleen Linton had been deceased for at least several hours. The extant Observation and Engagement policy is a document in excess of twenty pages. It advises staff to enter a patient's room if the patient is observed from outside the room as not having moved or if the patient is not seen to be breathing. Joleen Linton's observation chart recorded at 0100 hours that she, together with all other patient's on the ward, were "*IB - In bed*", not specifying the sleeping position as was necessary. The policy required further confirmation that a patient was safe and well on the occasions that a patient had not changed sleeping position since the previous observation. It was not readily apparent from the form whether this had been done.
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 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: (1) The practicality, adequacy and reliability of hourly observations; (2) Evidence indicated that in consequence of lighting, distance and obstructions it was not practical to reliably assess, through the door window, whether a patient was breathing; (3) The recording of the patient's position in bed was not accurately recorded on the observation chart. At least one entry was, having regard to the evidence, obviously erroneous; (4) Potential areas of concern, in relation to the completion of the observation chart, were not detected on the night; (5) There was a reluctance by members of staff to enter a patient's room to conduct observations; (6) The extant Trust policy, in relation to observations, lacks the necessary clarity, direction and succinctness that can readily be understood and applied by the members of staff who undertake the observations on the ward.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or 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 20th June 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: [redacted] (and Tony Hall Alsters Kelley Solicitors); and, [redacted]. 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	**25th April 2017**