Regulation 28: Prevention of Future Deaths report

Dawn Patricia GILL (died 02.06.18)

	THIS REPORT IS BEING SENT TO: **1. Dr Alistair Chesser** **Chief Medical Officer** **Barts Health** **Royal London Hospital** **Whitechapel Road** **London E1 1BB**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 12 June 2018, one of my assistant coroners, William Dolman, commenced an investigation into the death of Dawn Patricia Gill, aged 33 years. The investigation concluded at the end of the inquest yesterday. I made a determination that death was drug related, as follows. Dawn Gill was a long term drug user and took illicit drugs whilst in the Royal London Hospital, on top of her prescription medication (which included methadone), unintentionally causing her death. Having last been seen between midnight and 12.30am on 2 June 2018, her room was checked at 1am, 2am and later, but her presence on the floor under a pile of clothes was not detected until approximately 10am, by which time she had died. Hospital CCTV was never viewed. It is unclear at what point detection might have saved her life.

4	**CIRCUMSTANCES OF THE DEATH** The medical cause of death was: 1a methadone overdose.
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. Ms Gill was a long term drug user and, based on her history, was likely to take illicit drugs whether she was in or out of hospital. However, while she was in hospital, no nursing care plan was made to take this into account, for example by acknowledging the higher risk that it brought. One nursing sister was not even aware that staff suspected Ms Gill of going off the ward to take drugs. 2. Ms Gill was prescribed methadone in hospital and died of a methadone overdose, but her drug chart was not available at inquest and appears to have been lost. If the drug chart was lost during her life, then that has implications for her care. If it was lost after her death, then that would not have affected care but, how ever innocent the true explanation, it leaves the trust open to an accusation of trying to cover up evidence. When ever it was lost, its absence is very disappointing. The Barts legal representative at inquest was unaware until I asked to see it on the day that it was missing. He had taken on the file from a colleague a week earlier. He noted that my coroner's officer had not provided the trust with the report of the post mortem examination until the day before, so he had not known that death was the result of a methadone overdose. This was because the trust had not provided the statements requested. However, Ms Gill had been found in her room on the ward surrounded by drug paraphernalia, so it would have been evident to staff at the outset that drug toxicity was a potential cause of death. 3. Ms Gill's room was described as having been searched on numerous occasions overnight, by more than one person, the first time approximately half an hour after she had last been seen, yet her presence under clothing on the floor was not detected until 10am the following day.

	I heard nursing evidence that Ms Gill could not possibly have been in her room at the time of searching, but with the benefit of the CCTV it is now evident that she was. 4. Ms Gill was thought to have left the ward for a cigarette some time before 12.30am, though she was not actually seen leaving. She was wearing her night things. When her absence was discovered, hospital security personnel were not alerted. They could have viewed the CCTV. If they had done so, they would have realised that she had never left the ward. Hopefully, this would have prompted a redoubling of the search effort of the ward. There was confusion about the circumstances when the missing person policy should be followed. I was told that the policy is not clear. The responsible nurse said it was in the back of her mind to contact security and she did not know why she had not. The sister in charge said that she would not contact security for the first two hours. The director of nursing said the contact should be immediate. The clinical site manager and the responsible nurse disagreed about the nature of the conversation between them regarding contacting security. Neither of them had made a note. There seemed to be a lack of clarity.
6	**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 15 January 2019. 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 following. • HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • Care Quality Commission for England

	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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 16.11.18