REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted]ood, Managing Director, Central Medical Services (CMS), Linby, Nottinghamshire** **2. Care Quality Commission**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of Nottinghamshire
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 the 9th March 2018, I commenced an investigation into the death of Dr Polly Joanne Drew, aged 35 years. The investigation concluded at the end of the inquest on 30th November 2018. The conclusion of the inquest was Suicide. Dr Drew took her own life by injecting herself with anaesthetic agents (Propofol and Atracurium) acquired from the medical centre at Donnington Racetrack the day prior to her death. She had been working there as the Duty Doctor, employed by Central Medical Services, a Private Medical Service that provides medical cover for a variety of events such as motor racing.
4	**CIRCUMSTANCES OF THE DEATH** Dr Polly Drew was was known to have Bipolar Disorder, a diagnosis made in 2009. She had made a number of previous self harm attempts. She had been found to have needles and syringes in her possession in an operating theatre in April 2012, whilst working as an Anaesthetic trainee at Nottingham University Hospital NHS Trust (NUH), and then in July 2012 injected herself with Remifentnil, an opioid anaesthetic drug, again in the Operating Theatre, leading to a respiratory arrest. In 2016 she developed renal failure following a collapse, secondary to significant alcohol intake and likely other drugs. Thereafter she struggled with low mood, but was able to work as a GP trainee in a Practice in Nottingham. Her working hours and patient contact was limited, with no out of hours evening or overnight work, adaptations that were made by her Supervising Trainers on the Nottingham GP Training scheme. The GMC were involved in assessing her Fitness to Practice from 2012 to 2016. Her GP, treating Consultant Psychiatrist, and the General Practice where she was working, were unaware of her working additionally for Central Medical Services. Dr Drew was recommended to work at Central Medical Services by a [redacted], a Consultant in Anaesthetics/Critical Care. I understand she was known personally to him. This was a verbal recommendation, with CMS not taking up any written references, nor completing a DBS check prior to DR Drews employment
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 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. The recruitment process for the appointment of a Doctor to a position of such significant responsibility, with access to anaesthetic drugs, is completely inadequate. None of the above appears to have been known to [redacted] when Dr Drew was appointed. Dr Drew worked alone, putting herself and members of the public, for whom she had medical responsibility, at potential significant risk.
6	**ACTION SHOULD BE TAKEN** 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by the 29th April 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. For the avoidance of doubt, I will require a response from Central Medical Services only. I ask that the CQC undertake a visit to Central Medical Services after 29.4.19, to review the recruitment policies and practice to ensure it is safe, and report back to me thereafter.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted], the father of Dr Polly Drew 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	**24th February 2019** **Dr E A Didcock**