Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive** **Norfolk and Suffolk NHS Foundation Trust** **Hellesdon Hospital** **Drayton High Road** **Norwich** **NR6 5BE**
1	**CORONER** I am Jacqueline LakeJacqueline LAKE, Senior Coroner for the Coroner Area of Norfolk
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 29 December 2020 I commenced an investigation into the death of Lewis Robert BEGLEY aged 35. The investigation concluded at the end of the inquest on 13 September 2022. **The medical cause of death was:** 1a) Central Nervous System and Respiratory Depression 1b) Combined Drug Toxicity 1c) 2) **The conclusion of the inquest was:** Misadventure and Neglect contributed to the cause of death.
4	**CIRCUMSTANCES OF THE DEATH** Mr Begley was placed on Section 2 of the Mental Health Act and admitted to Samphire Ward, Chatterton House on 12 December 2020. He was placed on 4 times per hour observations when in communal areas and general hourly observations when he was in his bedroom. Mr Begley was seen to be acting in a suspicious manner during the early hours of 15th December 2020 whilst in the communal area. On 15th December 2020, Mr Begley gained access to the medicine room between 02.29.04 and 02.29.23 and again between 02.31.10 and 02.45.51. Upon being found in the medicine room, there was a failure to escalate risk to relevant persons. In addition, consideration was not given to further safeguarding checks in ensuring Mr Begley's safety. Multiple policies and practices were not followed adequately including the: Therapeutic Observations Policy, Searching Policy, Management of Medicines Policy. Inaccurate and inadequate information was handed over to other members of staff on shift and coming on shift. On the morning of the 15th December 2020, Mr Begley was found unresponsive in his room. CPR was commenced by staff. Emergency Services attended and Mr Begley was pronounced dead at the scene. At post mortem, a split plastic bag, containing 2 [redacted] in addition to other tablets of shape, colour and size which were unidentifiable, were found in Mr Begley's rectum.
5	**CORONER'S CONCERNS**

	During the course of the investigation my inquiries 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. Evidence was heard that medication is kept in a locked room and in locked cabinets, in accordance with legislation. However, there is no record kept as to what medication is stored and how much, particularly [redacted] which is a drug subject to misuse, in a mental health hospital where many patients have a history of drug misuse and suicidal ideation and actively seek out the drugs cupboard. 2. On a patient accessing medication, there is no knowledge as to whether anything has been taken and if so, how much, thereby limiting knowledge as to what treatment is to be considered and what action to be taken 3. Evidence was heard that there is no fixed training given to doctors with regard to the administering of [redacted] in the event of there being a suspected drugs overdose.
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 November 21, 2022. 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 • Mr and Mrs Begley, parents • And [redacted] sister I have also sent it to • Care Quality Commission (CQC) • Department of Health • HSIB • Healthwatch Norfolk • NHS ENGLAND (NHS IMPROVEMENT) • NSFT Legal Services who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 26/09/2022**  **Jacqueline LAKE** **Senior Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH