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. DARTFORD AND GRAVESHAM NHS TRUST** **2. KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST**
1	**CORONER** I am Patricia Harding, senior coroner, for the coroner area of Mid Kent & Medway
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 30th June 2023 I commenced an investigation into the death of Sarah Rhiannon Keen aged 32. The investigation concluded at the end of the inquest on 29th February 2024. The conclusion of the inquest was that Sarah Keen died as the result of an accident from the combined effect of ingesting fluoxetine and dihydrocodeine in the presence of cocaine.
4	**CIRCUMSTANCES OF THE DEATH** Sarah Keen had spent much of her young life in secure hospitals following a diagnosis of emotionally unstable personality disorder. She was both a risk to herself and others on occasion. In 2022 she was transferred to the Medway mental health team and was moved into supported accommodation as it was clear that she was not deriving much benefit from long hospital admissions. She required assistance with most activities of daily living including managing her medications. On the 17th April 2023 she was arrested [redacted]. She was described as intoxicated and having taken a number of gabapentin tablets. She was conveyed to Darent Valley Hospital when she was de-arrested and admitted for medical treatment, it having been established that she was anaemic. She received a blood transfusion. Over the course of the admission she made multiple attempts to leave the hospital, on one occasion shouting that she was going to kill herself [redacted]. Sarah was seen by psychiatric liaison nurses on 18th April 2023 who determined the risk of self harm to be high and recommended that she be provided with 1:1 care. A deprivation of liberty order was put in place to ensure that she received medical treatment. On 19th April 2023 she was seen by a psychiatrist at which point she was discharged back to the community mental health team, an action plan with coping strategies full future trigger points was sent to her community team and a note was placed by the psychiatrist in the medical records to indicate the above but also that further DSH was likely- 1 to 1 recommended. On the evening of 19th April 2023 Sarah was discharged from the hospital and returned to her supported accommodation accompanied by a member of the hospital's enhanced care team who left at the point of her arriving at the address. She had been discharged with seven days of medication. The enhanced carer was carrying one of Sarah's bags which

	she gave to the support worker who answered the door. Sarah stayed up for much of the night and the following morning indicated to the support worker that she wanted to go to sleep and shouldn't be woken. She was checked at her medication times but left asleep at which time she was snoring. She was checked again in the evening and was found to have died. A post mortem examination determined the medical cause of death to be multi drug toxicity she having taken near fatal levels off fluoxetine and dihydrocodeine in the presence of cocaine.
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 enhanced carer had not been told the reason that she was providing one to one care for Sarah, was not aware of any issues in relation to mental health, the fact of the deprivation of liberty order, or that Sarah was a risk of deliberate self harm including by overdosing on prescribed medications. She was not aware that Sarah had been discharged with seven days of medication or that her medication was being held on her behalf by another in the community. Although it was unusual for her to accompany a person with capacity to their address it was not unusual for her to accompany those without capacity. As a consequence the support worker who was on duty at the time that Sarah returned to her accommodation was not aware from an independent source that Sarah had been discharged with seven days of medication, Sarah lied to the support worker when she was asked whether she had been given any medication disclosing only the fact that she had been given ferrous sulphate which she handed over when her bag contained seven days of the medication which she subsequently ingested with fatal results. Even recognising medical confidentiality, those with a caring role who have not been provided with relevant information cannot meet the needs of the patient if they do not know what the risks are or know when it is appropriate to bring information to another professional charged with the care of the patient be it a nurse, doctor or support worker (2) The note left by the psychiatrist on the medical records did not contain any recommendations as to medication. The psychiatrist was aware that Sarah's medication was being held by her support workers as a result of the risk of mismanagement by overdosing. He was also aware that it was policy for the hospital to dispense 14 days of medication on discharge. He did not consider asking the discharging doctor to not provide Sarah with any medication on the basis that there was already a prescription in the community and although he considered that it was appropriate for the quantity of discharge medication to be reduced to seven days to reduce the risk of overdose, he did not communicate this to the medical team within the note. (3) The note left by the psychiatrist on the medical records contained the abbreviation DSH. it was clear from the evidence given at the inquest that this was not universally understood by the medical team to refer to deliberate self harm. Although the Trust has taken some action following the evidence being given at the inquest in that the psychiatrist after giving evidence sent an e-mail to his team detailing his reflections iteam to request that consideration be given to a number of matters in dealing with patients at the hospital. Having considered the e-mail I did not regard this as meeting the extent of my concerns
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 30th April 2024. 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 Family of Sarah Keen, Dartford & Gravesham NHS Trust, and Kent & Medway NHS and Social Care Partnership Trust 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	**4th March 2024** **Patricia Harding** **Senior Coroner Mid Kent & Medway**