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. The Department of Health**
1	**CORONER** I am Miss Stephanie Haskey, 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** **From 17th to 27th November2014 the death of Rebecca Louise Overy was the subject of an Article 2 Inquest. It was found that Miss Overy had died as a result of hypoxic brain injury as a result of asphyxia whilst in adult secure mental health detention. The jury returned a Narrative Conclusion.**
4	**CIRCUMSTANCES OF THE DEATH** **Miss Overy's fatal injury was self- inflicted, and occurred whist she remained on the adult admission ward. She had been transferred there from Child and Adolescent secure mental health detention the day after her 18th birthday, without any prior visit to the adult intuition and without any plan for a gradual transition, given Miss Overy's particular circumstances, despite this being proposed by her adolescent responsible clinician.**
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.That the immediate transfer of Miss Overy the day after her 18th birthday was not in her best interests, was detrimental to her mental health and occurred purely due to the operation of s 30 of the Health and Social Care Act, whereby the commissioners were obliged to arrange an immediate transfer, and the clinicians to concur with it, lest they be in breach of the act. 2. That there is no provision for secure mental health care for young adults in the age range 18-24, with a clinical picture similar to Rebecca's.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 - 2 - 15. 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: I have also sent it to: 1 [redacted] 2 [redacted]k 3 [redacted] 4 [redacted] 5 [redacted] 6 [redacted] 7 [redacted] 8 [redacted] 9 [redacted] 10 [redacted] 11 [redacted] 12 [redacted] (mother) 13 [redacted] (father) 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	**[DATE]** 17 - 12 - 14 **[SIGNED BY CORONER]** **Stephanie Haskey**