**ANNEX A**

**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**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. Ms Melanie Walker, Chief Executive of Devon Partnership Trust.** |
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| 1 | **CORONER**<br><br>I am John Geoffrey Tomalin Deputy Coroner, for the coroner area of Exeter and Greater Devon. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 3rd February 2015 I commenced an investigation into the death of Diane KNIGHT, 61 years old. The investigation concluded at the end of the inquest on 7th October 2015. The conclusion of the inquest was 'Took her own life'.<br>1 (a) Hanging |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Diane Knight had a significant history of mental illness including Depression Anxiety going back to 2012 following a diagnosis of Osteoporosis. She received various treatments both drug related and ECT. There have been several attempts by Mrs Knight to end her life by drug overdose. On the 3rd February 2015, whilst as a voluntary patient of the Ocean View Ward of North Devon District Hospital in Barnstaple, she hung herself with her belt from the door to her room. Her room has a door in which there is a window with a shutter that can be opened both from the inside and the outside. However it appears to have been an acceptable practise where patients could cover the outside of this window with a towel to stop light intrusion at night, when staff checked on the patients, to prevent light from entering their rooms and disturbing their sleep at night. Diane Knight had put a towel over her door and the window but that towel had hidden a belt end that was trapped by the door against the door-jamb from which she managed to hang herself. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) The continued practice of putting a towel over the door could hide an attempt by a patient to harm themselves or end their life such as here with a belt end being trapped by the door against the door jamb. |

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|   | (2) The continuation of this practice may prevent staff being properly able to monitor the patients on the Unit, therefore this practice should be reviewed.<br>(3) An alternative method for preserving patient privacy should be considered that would not allow a patient to conceal an attempt to cause themselves harm. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe your organisation have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 17th December 2015, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br>(1) [redacted] Husband<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **22nd October 2015** **John Geoffrey Tomalin** |