REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW
1	**CORONER** I am John Gittins Senior Coroner, for the coroner area of North Wales (East and Central)]
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 20th November 2014 I commenced an investigation into the death of Danielle Rhian Robinson aged 21. The investigation concluded at the end of the Inquest held with a jury on the 25th of May 2016. The conclusion of the Inquest was that Miss Robinson's death was the result of Misadventure. The medical cause of death was I(a) Post Cardiac Arrest Hypoxic Brain Injury with Cerebral Oedema due to 1(b) Ligature Strangulation
4	**CIRCUMSTANCES OF THE DEATH** (1) Miss Robinson was a 21 year old who was detained under s.3 of the Mental Health Act at the Heddfan Unit of Wrexham Maelor Hospital. During the time she was a patient at Heddfan she had repeatedly self harmed, primarily by the placing of ligatures around her neck. (2) On the 13th of November 2014 she was found unresponsive in her room with a ligature around her neck. At this time, despite earlier episodes of both self harm and absconding from the unit she was on level 1 observations (being every three hours). Despite resuscitation attempts and subsequent treatment she died on the 16th of November 2014.
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 Therapeutic Engagement and Observation Policy presently adopted by BCUHB is not being rigorously followed by staff with the result that opportunities to escalate the level of observations when required are being missed.

	(2) That the current Therapeutic Engagement and Observation Policy there should be reviewed with consideration being given to implementing a system for situations where there is a serious event which places a patient at risk of immediate or imminent harm, that there should be an automatic escalation of observation levels to level 3 or 4 (within eyesight or arm's length respectively) for a designated period and/or one to one engagement with the patient so as to provide an instant "safety net".
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 27th July 2016 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, [redacted] (Parents of the Deceased) 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] 31st May 2016** **[SIGNED BY SENIOR CORONER]**