REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT DATED 5 DECEMBER 2017 IS BEING SENT TO:** **Group Chairman, Ludlow Street Healthcare.** **Family of the deceased Stephanie Cave.** **Deputy Chief Medical Officer, Welsh Government.** **Chief Coroner.**
1	**CORONER** I am Philip Charles SPINNEY, Area Coroner, for the coroner area of South Wales 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 18 August 2016 an investigation was commenced into the death of Stephanie Cave. The investigation concluded at the end of the inquest held on 6 November to 16 November 2017. The conclusion of the inquest was the answers to a series of questions raised by me and answered by the Jury: In summary the Jury concluded that Miss Cave intended to take her own life. They further concluded that there were no acts or omissions in the overall care and treatment given to Miss Cave that probably contributed to her death.
4	**CIRCUMSTANCES OF THE DEATH** Stephanie Cave first started to experience a deterioration in her mental health in 2013 when she first started restricting her diet; later there was a significant deterioration in her functioning with self-harming, obsessional compulsive behaviour and speaking of hearing a derogatory voice associated with self-harming behaviour. She made a number of attempts to end her life. She had two periods of admission to hospital the second in September 2015 when she was admitted to the Dorothy Pattison Hospital under the provisions of the Mental Health Act. In January 2016 she was transferred to Heatherwood Court, a private hospital operated by Ludlow Street Healthcare as her needs could not be met on an acute ward. Miss Cave initially appeared to show improvement in her clinical state with her mood and affect improved. However, there were regular incidents of self-harm and of tying ligatures around her neck. In the months of May and June there were multiple incidents which required intervention by staff. Following this there was a sustained improvement commencing from the 7 July. However on the 17 August 2017 she was discovered with a ligature around her neck which sadly led to her death.
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) The evidence revealed that there was an inconsistent approach taken by staff when conducting and recording enhanced observations on patients detained under the Mental Health Act and at risk of self-harm and suicide when asleep. (2) The evidence also revealed that there was no training provided and no written guidelines on how such observations should be completed and how they should be recorded in the observation forms. (3) The evidence also revealed that precise times of such observations were not routinely being recorded.
6	**ACTION SHOULD BE TAKEN** **(1) Consideration should be given to reviewing the process of conducting and recording enhanced observations of patients detained under the Mental Health Act and at risk of self-harm or suicide.** (2) **Consideration should be given to introducing training and written guidance on how to conduct and record enhanced observations of patients detained under the Mental Health Act and at risk of self-harm or suicide.** In my opinion action should be taken to prevent future deaths and I believe you and 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 **30 January 2018**. 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 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	**SIGNED:** **Mr Philip C Spinney** **HM Area Coroner**