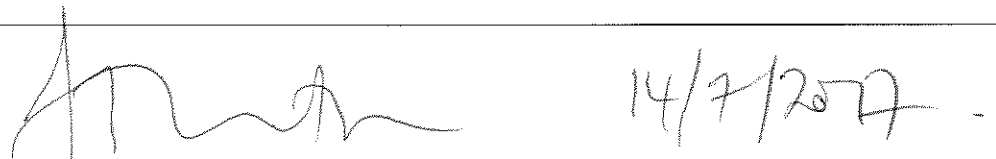
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Secretary of State for Health** **2. Sussex Partnership Foundation NHS Trust**
1	**CORONER** I am James Healy-Pratt, assistant coroner, for the coroner area of East Sussex.
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 9 November 2016 I commenced an investigation into the death of Sabrina Michelle Walsh, aged 32. The investigation concluded at the end of the inquest on 6 July 2017. The conclusion of the inquest was that Sabrina Walsh deliberately chose to attach a ligature to herself but the evidence does not fully explain whether or not she intended that the outcome be fatal. This was contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH (JURY FINDINGS)** The deceased was detained under the Mental Health Act as a patient in Woodlands Acute Care on 31 October 2016. She was found hanging with a ligature around her neck which had been slotted over the door through the closure. Sabrina deliberately tied and applied the ligature to herself. The lack of formal assessment had direct impact on Sabrina as if she had a risk assessment she would have been on correct observations therefore reducing the risk of self harm. The staff at Woodlands did not effectively appreciate the needs of Sabrina, which resulted in a serious failure of her care. If they had followed procedure and placed her on one to one observations this would have greatly reduced the opportunities to harm herself. Overall if correct procedures were followed they would have had a positive effect on Sabrina and the level of care received. By not following procedures this has had a clear and direct effect on her passing. This is a gross failing of medical care from staff at the Woodlands.
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. – The lack of CCTV in corridors and communal areas at Woodlands Acute Care, St

	Leonards on Sea, which would enhance location of vulnerable patients where observations do not immediately locate them. Valuable minutes would be saved in locating vulnerable patients if CCTV was installed.
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 8 September 2017. 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: Birnberg Peirce, solicitors for the family. Care Quality Commission 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	 **James Healy-Pratt** **14 July 2017**