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. **Bondcare , Clarendon Care Home** 2. **Thornton Heath medical Practice GP** [redacted] 3. **Croydon County Council – Adult Social Care, Immigration & Asylum** 4. **Care Quality Commission**
1	**CORONER** I am Sonia Hayes, assistant coroner, for the coroner area of South London
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 18th July 2017 an investigation was commenced into the death of Yong Kang Hong age 60. The investigation concluded at the end of the inquest on 10th August 2018. The conclusion of the inquest was the medical cause of death being 1a Hypoxic Brain Injury 1b Cardiac Arrest (resuscitated) 1c Suspension (Clinical) and the Conclusion Suicide (contributed to by neglect)
4	**CIRCUMSTANCES OF THE DEATH** An asylum seeker with very little English was transferred from hospital to a care home. Displayed self-harm and suicidal behaviour including attempting to strangle himself with his call bell, this was removed. On 5th July the GP was significantly concerned about his suicidal behaviour to make an immediate referral to mental health services and advised constant observations. He could not communicate with staff and no interpreter was sought. His call bell was returned to him, no risk assessment was conducted and no further input from the GP was sought. His call bell was returned to him and on the morning of 12th July he used it to hang himself from the curtain rail in his bedroom.
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) His GP made an immediate referral to mental health services and advised constant observations, however: (a) the observation regime advised by the GP was not implemented (b) whilst awaiting a formal review of his mental state, no interpreter was sought in the meantime to assist with assessment of his needs due to

	issues of confusion between the social work team and the care home about responsibility for funding (c) no risk assessment was carried out prior to making the decision to return his call bell. (2) No further advice was sought from the GP or other appropriate clinician and he was left in social isolation without any means to express his distress, no safety net and no therapeutic engagement (3) Evidence at the inquest was that care home staff did not receive training in how to carry out risk assessments
6	**ACTION SHOULD BE TAKEN** 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 29th April 2019. 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: Bondcare Clarendon Care Home, Thornton Heath Medical Practice GP [redacted] Croydon County Council and the 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	**Sonia Hayes** S.M. Hayes