REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Surrey and Borders Partnership NHS Foundation Trust – For the attention of the Chief Executive, Fiona Edwards, the Medical Director, [redacted] and the Director of Quality (Nurse Director), [redacted].**
1	**CORONER** I am Alison Hewitt, Assistant Coroner for the coroner area of Surrey.
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** I commenced an investigation into the death of Sarah Anne Shepherd aged 26 years. The investigation concluded at the end of the inquest on 14th November 2013. The conclusion of the inquest jury was that (i) the medical cause of death was I (a) Hypoxic Brain Injury I (b) Traumatic Asphyxia and (ii) the Deceased died as a result of her own deliberate act (but the evidence did not establish, beyond reasonable doubt, whether she intended that act to cause her death) and her death was more than minimally contributed to by failures by the Trust to (a) refer her to the Psychiatric Intensive Care Unit, (b) observe her on the 12th September 2011 with sufficient regularity and (c) remove the bin liner from the waste bin in her bedroom.
4	**CIRCUMSTANCES OF THE DEATH** Sarah Anne Shepherd was a patient detained under the Mental Health Act in the Noel Lavin Unit of the Farnham Road Hospital. She had a significant history of self-harm. On the 12th September 2011she was found in her room with a plastic bin liner over her head, held in place by the cord of her hooded top. She was alive when she was found and was taken by ambulance staff to the Royal Surrey County Hospital where she died on the 13th September 2011.
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) It was clear from the evidence that the Trust has in place an Operational Policy concerning its Psychiatric Intensive Care Services. The Policy in place in September 2011 did not establish a clear process for the referral of an inpatient from an acute ward (or any other patient) to the Psychiatric Intensive Care Unit and it did not require the PICU to provide a written and reasoned response to the referral and to record the same on the patient's RIO (or other medical) notes. From the evidence heard, it does not seem that these concerns have yet been addressed or sufficiently addressed by amendment of the Operational Policy and consequential staff training.

	(2) It was apparent from the evidence that the nursing staff who found the Deceased in an unresponsive state on the 12th September 2011did not attempt to resuscitate her in accordance with the guidelines of the Resuscitation Council. They understood that resuscitation should be started if the patient was not "breathing" whereas the Council states that it should be started if the patient is not "breathing normally". The evidence heard as to what training the nursing staff had been given concerning when resuscitation should be started was unclear and confusing. It remains unclear whether the resuscitation training now being given to clinical staff (a) is fully and clearly in accordance with the current guidance of the Resuscitation Council and (b) includes training as to what observations should be taken and recorded. Further, it was apparent from the evidence that the resuscitation bags used by staff contain a laminated aide memoire which is itself misleading as it refers to the use of resuscitation when the patient is not "breathing" rather than "breathing normally".
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths by addressing the concerns set out above 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 10th February 2014. 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]. 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	**16th December 2013** **Alison Hewitt**