ANNEX A

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:** [redacted] **General Council**
1	**CORONER** I am Jacqueline Devonish, assistant coroner, for the coroner area of Northamptonshire
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 11 September 2019 I commenced an investigation into the death of Blaithin Grianne Buckley, aged 26. The investigation concluded at the end of the inquest on 13 September 2019. The conclusion of the inquest was that her death was a Misadventure and that the medical cause of death was: 1a. Hypoxic brain injury 1b. Out of hospital cardiac arrest 1c. Hanging 2. Emotionally Unstable Personality Disorder The jury found that the death had been contributed to by a breach of procedure at St Andrews in failing to lock the phone booth; an inadequate level of patient history transferred from Wootton Lawn to St Andrews (in particular the previous history of ligature by phone cord); an insufficient process for calling the ambulance service following the incident.
4	**CIRCUMSTANCES OF THE DEATH** Ms Buckley died on 30 April 2018 at Northampton General Hospital following being found hanging in a phone booth on the Bayley Ward at St. Andrews Healthcare on 26 April 2018 at 23:20, whilst on 5 minute observations. Contrary to the Trust policy, the phone booth door had been left unlocked. The Trust medical emergency team was alerted to the incident through ascom at 23:23. CPR and life support commenced to good effect. Upon being found Ms Buckley had been conscious. She then fell unconscious with fixed and dilated pupils. The experienced medical emergency team returned a pulse and rapid heart beat whilst awaiting arrival of an ambulance. The first ambulance arrived at 00:02, having been called at 23:44. Ms Buckley was transferred to Northampton General Hospital at 00:42 in a comatose condition. Brain stem testing on 30 April 2018 recognised that life was extinct.

	The critical care consultant at Northampton General Hospital gave evidence that he suspected that an earlier arrival at hospital would not have altered the outcome as 5 minutes was sufficient to establish permanent brain damage.
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 could 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 delay in calling for an ambulance to transfer Ms Buckley to the General Hospital in a clear medical emergency. There was no evidence before inquest to explain the delay between 23:20 and 23:44. Whilst it had been accepted that senior clinicians, with greater medical knowledge that the paramedics, formed the medical emergency team, St Andrews as a mental health setting was required to transfer Ms Buckley to A&E in any event. It was unclear whether the policies/procedures requiring the mobilisation of the medical emergency team included guidance on whether an ambulance should be called, and when.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you or 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 16 November 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 Person - [redacted] I have also sent it to [redacted] who may find it useful or of interest. 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	**16 September 2019** Jacqueline Devonish