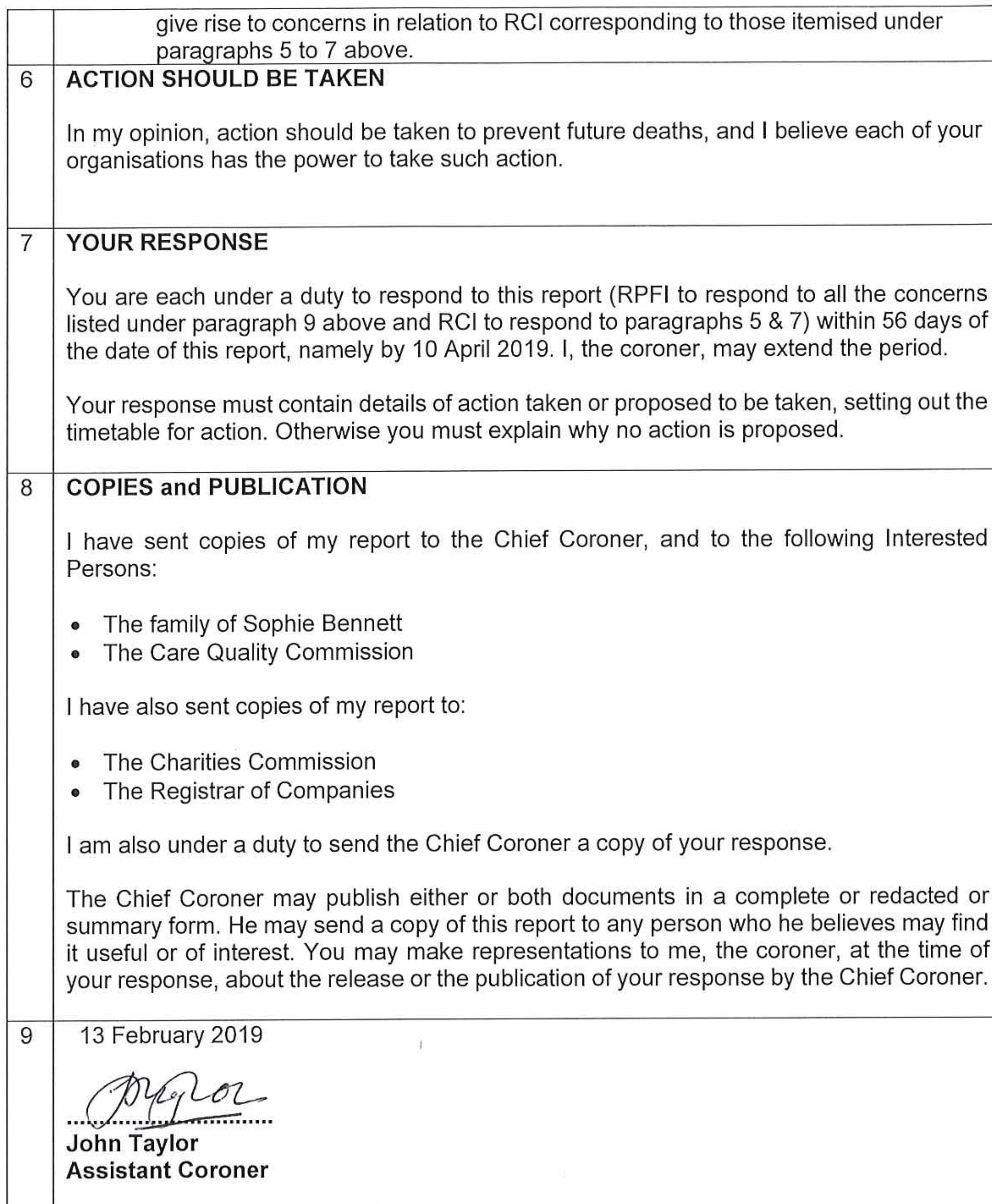
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • Richmond Psychosocial Foundation International ("RPFI"), and • Richmond Companions International ("RCI")
1	**CORONER** I am John Taylor, Assistant Coroner for the Coroner Area of West London.
2	**CORONER'S LEGAL POWERS** 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 19 September 2016, the Senior Coroner commenced an investigation into the death of Sophie Bennett, aged 19. The investigation concluded at the end of the inquest on 8 February 2019, which took place before me, sitting with a Jury. The conclusion of the inquest was: A. The medical cause of death was 1a. Hypoxic brain injury and pneumonia; 1b. Cardiac arrest (resuscitated) and 1c. Suspension. B. In their narrative conclusion, the Jury made the following findings, in relation to matters which they found to be contributory to Sophie's death: • The changes at Lancaster Lodge in and after January 2016, noting the following: 1. The uncertainty surrounding the discontinuation of external therapies contributed to a feeling of anxiety and uncertainty. 2. The departures of critical staff members including registered manager, clinical leads and key workers. 3. Introduction and effect of a regime perceived by Sophie to be akin to a "boot camp". 4. Replacement staff, across all levels were not adequately trained, skilled, educated or experienced and lacked the relevant numbers of staff. 5. Changes resulted in the deterioration in the care provided by Lancaster Lodge. 6. Inadequate rating by the CQC following the March 2016 inspection; 7. Changes ultimately resulted in the decision to move Sophie from Lancaster Lodge. 8. The changes impacted negatively on Sophie's wellbeing and upon her mental state. 9. Leadership and oversight of the RPFI board was grossly inadequate. 10. Consultation regarding the changes was not relayed effectively to both staff and residents. 11. The registered manager was told to leave without carrying out a sufficient handover or allowing a transition with residents and other staff members. 12. Various RPFI/Lancaster Lodge staff did not hold the relevant qualifications for the roles in which they were carrying out responsibilities. 13. Various observations that it was 'chaotic' staff were 'in the deep end' and 'learning on the job' this created a feeling for residents of generally being unsafe. 14. If it isn't broken why fix it, no need for the changes when Lancaster Lodge had been performing well for the residents, especially when it was operating 'at the peak of its powers' up to the end 2015. 15. Changes were based on a 1 day audit, grossly inadequate. 16. Advice provided by the founder and followed by RPFI staff without ever meeting or any knowledge of residents.

	• There were errors or omissions in the management of risk by RPFI (a company limited by guarantee, and a registered charity) between 28 April 2016 and 2 May 2016, noting the following: 1. Staff not trained or aware of crisis management and awareness of risks. 2. Didn't follow the appropriate crisis line advice to take Sophie to A&E in an ambulance. 3. Staff presented as being highly unsure about chain of command between the crisis line and RPFI management. 4. RPFI declining the care coordinator and treating psychiatrist visiting. 5. Grossly inadequate observation plan of Sophie put in place and not understood or followed. 6. Grossly inadequate steps at minimising access to ligature items or knowledge of past history involving ligature. 7. Very poor room searches, only looked for certain items and not trained in what to look for. 8. Only one night sleeping staff working for Lancaster Lodge with high risk residents. 9. Lack of staff awareness of risks to let Sophie close the door. • Neglect on the part of RPFI.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances found by the Jury were: "Sophie Elizabeth Alice Bennett died on the 4th May 2016 at Kingston Hospital from injuries caused by having applied a ligature on 2nd May 2016 at Lancaster Lodge, Surrey, a care home operated by Richmond Psychosocial Foundation International (RPFI). Sophie generally settled well at Lancaster Lodge and in particular from around September 2015 appeared to be making good progress until January 2016. After which changes implemented to the staff, therapy and the daily routine within Lancaster Lodge led to an "inadequate" finding by CQC in early March 2016. Following the safeguarding concerns raised by Richmond local authority, Wandsworth social services decided to find an alternative placement for Sophie. There were various concerns raised around 28th &29th April regarding Sophie's mental stability. A phone call to the crisis line was made by a staff member of Lancaster Lodge on the 28th April who was advised to call an ambulance to take Sophie to A&E which was not followed. On 2nd of May Sophie was presenting as anxious and self isolating and then was found at approximately 17:20 unresponsive in the bathroom and then was admitted to hospital."
5	**CORONER'S CONCERNS** During the course of the inquest, the evidence (and other papers produced to me) 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 governance of Lancaster Lodge, and of the staff, and others, working there during the material period, was inadequate in the following respects: 1. There was no "registered manager" who met the statutory criteria. 2. The staff were (despite RPFI's assertions to the contrary), generally, untrained, unqualified and too few in number. 3. There were no, or no adequate, checks and controls by the staff, or by the acting manager, on the keeping of essential documents, including risk

assessments and progress notes, which were, in consequence, themselves inadequate, unreliable and misleading - with corresponding risk to the safety of the residents.

4. The changes to which the determined circumstances refer were made following an audit by [redacted] but:
   - [redacted] was not qualified clinically, or in the field of mental health, to conduct that audit;
   - the audit conducted by him (which led to the proposals for change) took only a single day, which was grossly inadequate;
   - there was no, or no adequate, consultation with the staff, or by the staff with the residents, regarding the substantial changes introduced, and to be made; and
   - the changes were introduced at a "launch", with no, or no adequate regard to the negative impact of their sudden introduction on the mental stability of the residents.
5. Leadership and oversight by the Board of RPFI was grossly inadequate, in relation to:
   - the need to have in place robust employment procedures;
   - the matters listed under paragraphs 1 to 4 above;
   - the appointments of the clinically unqualified [redacted] and, later, the clinically unqualified art therapist as Clinical Lead, of a statutorily-approved registered manager, and of an adequate number of trained and qualified staff;
   - supervision and control of the changes introduced at [redacted] instigation;
   - decisions made by the (unqualified) acting manager and staff in relation to the treatment to be given to the residents, and other steps required to meet their needs, and safety;
   - communication with other agencies involved in the care of the residents;
   - the keeping and production (including to the Court, for the purpose of the inquest) of the Board's own records, communications and contracts; and
   - knowledge and performance of the Board's fundamental obligations, including their duty of candour (not least in the Board having failed to fulfil its mandatory obligation to report to the CQC five instances of admission of Lancaster Lodge residents to hospital).
6. Advice to the acting manager was provided by [redacted] - the founder of RPFI - and significant decisions regarding Lancaster Lodge, and the residents, were made by her (in each case as a "consultant" to the Board, rather than by the Board of RPFI), and were followed by RPFI staff, when:
   - [redacted] was neither a director, nor a Trustee, of RPFI (one Board member describing her role as "somewhat ambiguous", and the evidence suggesting that she was a "shadow director"); and
   - [redacted] had never visited Lancaster Lodge, and had never met (or had any, or any sufficient, knowledge of the residents).
7. The possibility of there being:
   - a conflict between the interests of [redacted] (who, it appears, may have had a personal or family connection with the ownership of Lancaster Lodge) and those of RPFI itself; and
   - financial impropriety, in relation to the lease under which Lancaster Lodge was (it seems) held.
8. The post-death investigations carried out on behalf of RPFI:
   - were inadequate, verging on self-serving, and not objective; and
   - give rise to concerns as to their veracity and accuracy (the authorship of certain supposedly contemporaneous statements being denied by the staff member whose name appears on them as their maker).
9. The facts that:
   - a director and trustee of RPFI is also the Chairman of RCI; and
   - [redacted] appears to have some family connection with the owner of RCI's premises



	give rise to concerns in relation to RCI corresponding to those itemised under paragraphs 5 to 7 above.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths, and I believe each of your organisations has the power to take such action.
7	**YOUR RESPONSE** You are each under a duty to respond to this report (RPFI to respond to all the concerns listed under paragraph 9 above and RCI to respond to paragraphs 5 & 7) within 56 days of the date of this report, namely by 10 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 copies of my report to the Chief Coroner, and to the following Interested Persons: • The family of Sophie Bennett • The Care Quality Commission I have also sent copies of my report to: • The Charities Commission • The Registrar of Companies I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both documents 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	13 February 2019 [signature] .... **John Taylor** **Assistant Coroner**