REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Heathcotes Group** **2. Care Quality Commission**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of Nottinghamshire
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 the 15th September 2020, I commenced an investigation into the death of Rebecca Begg, aged twenty one years. The investigation concluded at the end of the inquest on the 17th November 2021. The conclusion of the inquest was a Narrative Conclusion as follows: Rebecca Begg, 'Becca', died at Heathcotes, Moorgreen in the early hours of 15.9.20, from the [redacted]. She had [redacted] some 10 to 15 minutes prior, and this had been removed by staff. Becca had a diagnosis of Emotionally Unstable Personality Disorder, and had known high risk self harm and suicidal behaviours. Becca put a [redacted] as she was very distressed. This was a usual and repeated behaviour that Becca knew from previous experience, led to a reduction in her distress. Had the team at Heathcotes who were responsible for providing care for Becca properly assessed and understood her high level of risk, her care plans would have reflected both her risk and support needs, specifically that she had previously [redacted] repeatedly over a short time period leading to unconsciousness. Had there been a Team Leader on duty overnight, present with the three other members of staff, on a balance of probability, this would have led to the allocation of a member of staff to remain with Becca following the first [redacted] If Becca has been in line of sight observation following the first [redacted] as per her care plan, on a balance of probability, she would not have died. Becca's death was contributed to by Neglect.
4	**CIRCUMSTANCES OF THE DEATH** In brief, Becca died at Heathcotes, Moorgreen, a community specialist unit for adults with Emotionally Unstable Personality Disorder, or EUPD. She had moved there following her discharge from The Priory hospital on 31.8.20, some two weeks prior to her death. At the point of discharge from The Priory, and at Moorgreen, she was a voluntary patient, but had been detained initially on admission to The Priory in June, on a Section 2 and then 3 of the Mental Health Act 1983. She had been detained six times

	previously, including for prolonged periods, because of the assessed high self harm risk. Becca had a long history of serious self harm, including [redacted]. On the night of her death she had [redacted] at approximately 22.45 hours. This was [redacted] by staff, and she seemed to settle with talking support and Diazepam. She was left in bed, and then found a few minutes later in her bathroom, blue and unresponsive, with a [redacted]. Despite [redacted] and her receiving resuscitation by staff and the Ambulance service, she did not respond and was pronounced deceased at 00.13 hours on 15.9.20.
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. – • Failure to monitor compliance with care plans, and a lack of robust incident reviews – whilst welcome changes are planned with improved audit and monitoring, this is not yet fully implemented • As yet untested 'observation level' support plans • A lack of inclusion of support workers in regular meetings about clients- it is these staff working each day with clients, that can contribute to progress review, and if necessary to a change in the support plans and/or risk assessments • No dedicated time for staff to read and digest care plans • Lack of clarity regarding who can instruct for a room to be stripped following an incident of serious self harm • Lack of a system for formalised contact with Nottinghamshire Healthcare NHS Foundation Trust (NHCT), including if Heathcotes are unhappy about the response from the Mental Health teams, a means of escalation to NHCT senior team
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 the **3rd February 2022**. 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.

	For the avoidance of doubt, I will require a response from the Heathcotes Group only. I would also expect the CQC to visit, and update me as to their findings and any action taken
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: 1. [redacted], parents of Becca 2. [redacted], Support worker, previously of Heathcotes 3. Nottinghamshire County Council 4. Nottinghamshire Healthcare NHS Foundation Trust 5. The Priory Group 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	**8th December 2021 Dr E A Didcock**