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:** **CHIEF EXECUTIVE AT THE WEST LONDON MENTAL HEALTH TRUST**
1	**CORONER** I am Chinyere Inyama, senior 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 3rd of January 2015 I commenced an investigation into the death of Nihad Ousta. The investigation concluded at the end of the inquest on 25th October 2016 with a narrative conclusion returned by the jury.
4	**CIRCUMSTANCES OF THE DEATH** Nihad Ousta was admitted to Coniston Ward, West London Mental Health Trust, under s2 Mental Health Act 1983. He suffered visible head trauma on 2 separate occasions before deteriorating and being transferred to Ealing General Hospital for further treatment. Whilst there he acutely deteriorated necessitating transfer to Charing Cross Hospital for a neurosurgical procedure. He was returned to Ealing General post procedure, later transferred to a nursing home for further management and then several months later admitted into St George's Hospital where he passed away.
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. – There was not and currently is not a protocol or other written guidance or policy for the management of head injury (to include frequency and range of general and neuro observations)
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 17th December 2016. 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 persons: [redacted] one of the daughters of Nihad Ousta. 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	**25th October 2016** **SIGNED BY CORONER**