Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1** [redacted], **Chief Executive, Oxford Health Nhs Foundation Trust**
1	**CORONER** I am Gemma BRANNIGAN, Assistant Coroner for the coroner area of Buckinghamshire
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 opened an inquest into the death of **Amanda Gibbens**. The investigation concluded at the end of the inquest on 21 February 2022. The medical cause of death was: Ia Hypoxic brain injury Ib Asphyxiation
4	**CIRCUMSTANCES OF THE DEATH** Ms Gibbens died on 13 July 2020 at Stoke Mandeville Hospital, Buckinghamshire. Ms Gibbens had been detained under Section 2 of the Mental Health Act at Ruby Ward at the Whiteleaf Centre, managed by Oxford Health NHS Foundation Trust. Whilst an in-patient, the deceased made attempts to self-harm including by using a [redacted] and making multiple attempts to [redacted]. Whilst she was in the de-escalation room on Level 3 constant observations, she obstructed her [redacted] – this action was not witnessed. She then suffered a cardiac arrest and despite resuscitation efforts she did not survive.
5	**CORONER'S CONCERNS**

	The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) 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. **Using a monitor screen for Level 3 constant "within eyesight" enhanced observations**. The jury found in this case that the deceased could not be seen at all times whist in the de-escalation area, because male healthcare staff moved from observing the female patient from their position in the doorway of the de-escalation room, to view via the monitor in the corridor, when the patient moved into the bathroom, to increase her privacy. Although the Observation policy has been updated since this death in July 2020, by the time of the inquest, the use of the monitor for performing L3 observations was not specifically addressed or prohibited. Although the head of nursing was clear that this should no longer be happening in practice, the current Matron of Ruby ward gave evidence that this was still happening, and although it was now being 'discouraged', it was not prohibited. 2. **Searching bedrooms on Ruby ward for prohibited items** The evidence in this case demonstrated that the deceased had prohibited items in her bedroom on Ruby Ward, including a [redacted] The search of the patient environment in July 2020 was not effective in identifying and removing items which could be used for self-harm by a detained patient under the Mental Health Act, who was at risk of self harm. The evidence heard at the time of the inquest in February 2022 was that the bedroom searching process does not always include looking into or underneath a patient's property in their room for concealed items, although some changes to the method and recording of searches are intended. A previous Report to Prevent Future Deaths to the Trust dated April 2019 also identified that the search process on Ruby ward was not effective.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/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 **21 April 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] I have also sent it to **Care Quality Commission** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 23/02/2022** **Gemma BRANNIGAN** **Assistant Coroner for Buckinghamshire**