ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Sheffield Trust**
1	**CORONER** I am Donald Coutts-Wood, assistant coroner, for the coroner area of South Yorkshire (West)
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. (1) Where – (a) A senior coroner has been conducting an investigation under this Part into a person's death (b) Anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and (c) In the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have power to take such action. (2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it. (3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner
	INVESTIGATION and INQUEST On 4th April 2013 I commenced an investigation into the death of Pamela Margaret Bailey, aged 68. The investigation concluded at the end of the inquest on 13th January 2014. The narrative conclusion was: That Pamela Margaret Bailey was admitted to Hawthorn Ward, Northern General Hospital, Sheffield on 30th September 2012, and detained under the Mental Health Act 1983. She became an informal patient in December 2012 and during February and March 2013 both escorted and unescorted leave took place. On 23rd March 2013 at approximately 1830 hours she left the ward without being observed. Her movements after that time are not known. She was found deceased on 29th March 2013 at a secluded location at Ladybower, Derbyshire. It is not clear what her intentions were when she left the ward or thereafter. The medical cause of death was 1a) Hypothermia.
4	**CIRCUMSTANCES OF THE DEATH** Pamela Margaret Bailey had been an in-patient at Hawthorn Ward, Northern General

	Hospital, Sheffield from the end of September 2012. She was initially detained under Section 2 and Section 3 of the Mental Health Act 1983 but then as an informal patient from December 2012. The intention was for Mrs Bailey to eventually be discharged home and escorted leave was commenced, to be followed by unescorted leave. On the 23rd March 2013, Mrs Bailey was on the ward at about 1830 hours. She exited the ward, obtaining egress through a locked door likely having observed the key code required. She was observed at 1831 hours on CCTV walking away from the Northern General Hospital, which was not only the last sighting of her, but also the last evidence of her whereabouts. She was found deceased on the 29th March 2013 at an isolated, secluded location close to Ladybower reservoir, Derbyshire. For the period 23rd March to the 29th March it was both very cold and there was heavy snow lying on the ground.
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. I have seen an action plan, which I am informed was created after the report of the Serious Incident Panel in September. It was last updated on the 9th January 2014. The **MATTERS OF CONCERN** are as follows. – (1) Door security – no final decision has been made yet, but my understanding is that it is proposed to introduce a system for all secure wards, whereby there is a dual system involving key code and swipe card. Is this the proposed alternative to the current system, and bearing in mind it is now about ten months since this incident, when is it proposed such action should be taken? (2) On Saturday 23rd March 2013 the staffing on Hawthorn Ward was only three, whereas it should have been (at least) four. Attempts had been made by the previous shift to obtain a replacement, although it had not involved contacting senior management, having failed to obtain a replacement by contacting either existing staff or flexi staff. The Action Plan reveals that as regards staffing there is a proposal that there will be no difference between weekdays and weekends, as is now the case. It also indicates that a senior manager is to be made available to manage and not as now also involved in clinical duties. Please confirm what action is to take place. (3) There was no photograph available, of Mrs Bailey, to the Police when she disappeared. This clearly raises a number of difficult issues, as to the obtaining and retaining of a photograph. What decisions have been made in this regard?
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 Monday 24th March 2014. 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, the family, the Trust and the Police. 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	**[DATE]** 27/1/14 **[SIGNED BY CORONER]**