REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Surrey and Borders Partnership NHS Foundation Trust – For the attention of the Chief Executive, the Medical Director and the Nurse Director.**
1	**CORONER** I am Alison Hewitt, Assistant Coroner for the coroner area of Surrey.
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 commenced an investigation into the death of Katherine Liana Bonaventura aged 28 years. The investigation concluded at the end of the inquest on 14th January 2015. The conclusion of the inquest jury was that (i) the medical cause of death was I (a) Haemorrhage I (b) Stab Wound to the Chest, (ii) the Deceased died as a result of her own deliberate act, whilst suffering mental ill health, but the evidence does not establish, beyond reasonable doubt, whether she intended that act to cause her death, and (iii) her death was more than minimally contributed to by failures by the Trust (a) upon her return to the Abraham Cowley Unit on 7th December 2012 to elicit information about issues arising during her overnight leave and (b) to assess sufficiently and immediately her mental state upon her return to the Unit following her overnight leave.
4	**CIRCUMSTANCES OF THE DEATH** Katherine Liana Bonaventura was a patient detained under the Mental Health Act in the Abraham Cowley Unit of St Peter's Hospital, Chertsey. Katherine Bonaventura was diagnosed as suffering paranoid schizophrenia and had a significant and recent history of violent self-harm. Her detention had commenced in October 2012 and she had undertaken her first overnight leave from the Unit from the 6th December to the 7th December 2012. During that overnight leave, which the deceased spent with her family, she consumed alcohol and, on the morning of the 7th December, was seen to be in a psychotic state and staring at a kitchen knife block. These facts were of relevance to the deceased's risk of self-harm but they were not elicited from the family member who returned the deceased to the Unit. Further, the deceased's mental state was not immediately or sufficiently assessed upon her return to the Unit. In fact, Katherine Bonaventura returned to the Unit with a concealed knife, taken from the kitchen knife block at home, with which she fatally stabbed herself a few hours later. The evidence suggested that if the full picture had been elicited when Katherine Bonaventura returned to the Unit, her mental state may have been more thoroughly

	examined, she may have been searched and she may have been kept under greater and/or more regular observation.
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. – It was clear from the evidence that the Trust had and has in place Guidelines entitled "Working Age Adults Inpatient Leave of Absence Guidelines for Detained Patients" dated November 2011 and reviewed in July 2012. Those guidelines state, "Upon return from leave, an assessment of the patient should occur and the family member, carer should be consulted to ensure any issues arising during leave are noted. The outcome of this discussion should be documented in the patient's clinical record." It was apparent from the evidence that (i) the consultation with the family member / carer may consist of no more than an exchange of a few words in the presence of the patient, (ii) it is sometimes difficult for a family member / carer to provide all relevant information to staff in those circumstances and (iii) if staff are not immediately aware of any issues arising, their "assessment of the patient" may consist of no more than an exchange of a few words in the reception area. It is, therefore, of great importance that staff elicit as much information as possible about the leave and any concerns arising, at the point of the patient's return. It is of concern that there is no system in place to ensure that a sufficiently thorough consultation takes place with the family member / carer, which is designed to elicit as much information as possible as soon as possible. One nurse stated in evidence that it is now his personal habit to escort the family member / carer off the Unit so that he can conduct a further, private, consultation, but that not all nurses do so. It is also of concern that there is no system in place to ensure that a sufficient mental state assessment of the patient is conducted, and its outcome is recorded, at the time of arrival back on the Unit.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths by addressing the concerns set out above 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 25th March 2015. 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 Person : [redacted] 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	**28th January 2015** **Alison Hewitt**