REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive Hywel Dda University Health Board**
1	**CORONER** I am Gareth Glyn Lewis Area Coroner for the coroner area of Carmarthenshire and Pembrokeshire.
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 19th December 2012 an investigation into the death of Laura Hill then aged 21 was commenced. The investigation concluded at the end of the inquest on 27th November 2014. The conclusion of the inquest was a narrative verdict namely that the deceased had suspended herself by a ligature from the branch of a tree in a wooded area near to the Springfield Retail Park on Fishguard Road, Haverfordwest but the question of intent remains unclear. The medical cause of death was hanging.
4	**CIRCUMSTANCES OF THE DEATH** (1) The deceased had had a difficult time growing up which saw her bullied at school, suffer depression and begin taking controlled drugs. She also lost a young son in January 2011 and her boyfriend of the time took his own life in August 2012. (2) On 11th December 2012 the deceased took a large overdose of prescription tablets which nearly killed her. She was admitted to and treated at Withybush General Hospital for a period of 4 days and then transferred as a voluntary patient to the St Caradog Ward ('the Ward') at Bro Cerwyn Hospital in Haverfordwest. (3) On arrival at Bro Cerwyn, the deceased was assessed as having "varying suicide risk" and it was felt that she would benefit from admission in view of her depression, substance misuse, unresolved bereavement issues and recent suicide attempt. She was placed on Level 2:15 observations. At this time she was described as "jovial, bright and interacting well with others". (4) At 19.15 hours that day the deceased demanded to leave the Ward in order to source heroin. Staff on the Ward tried to dissuade her from leaving but she was adamant. She was allowed to discharge herself against medical advice. (5) In the early hours of 16th December the deceased was returned to the Ward by Police Officers who had detained her under section 136 of the Mental Health Act. (6) Upon readmission to the Hospital the deceased was emotional, in a distressed state, sobbing and tearful. The assessing doctor, placed her back on Level 2:15 observations and stated that should she seek to leave again then consideration

	(7) At 14.45 hours on 16th December 2012, the deceased absconded from the Ward. Staff on Ward did not see her leaving the Ward. The alarm was raised by other patients. Staff from the Ward pursued her and persuaded her to return back to the Ward. The assessing doctor was not notified of this attempt to abscond nor was there a further assessment of the deceased's mental health. (8) At approximately 18.15 hours later that day the deceased absconded from the Ward again. When a member of staff got to the door of the Ward she was nowhere to be seen. The Police were notified and there was an extensive search to try and locate her. (9) The deceased was found hanging from the branch of a tree in a wooded area near to the Springfield Retail Park at approximately 07.55 hours by members of the public.
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. – (1) That there appears to be a breakdown in the transition and passing of information between the Child/Adolescent and the Adult Mental Health Teams. (2) Staffing levels on the Ward need to be reviewed as it was felt that staffing resources were stretched at the relevant time (1 nurse and 3 support workers on a 16 bed acute ward). (3) There was a training need identified in relation to the section 136 procedure when patients are handed over by the Police. (4) There was a training need identified in relation to what constitutes 'absconding' and what should be done by staff following an incident of absconding. (5) The door policy on the Ward needs to be reviewed as a patient was able to abscond without staff noticing. (6) There was a training need identified in relation to Personality Disorders. (7) There was a training need identified in relation to powers of detention and when those powers can and should be used.
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 10th April 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 Persons: [redacted] c/o Lester Morrill Solicitors, 27 Park Square West, Leeds, LS1 2PL [redacted] c/o JCP Solicitors, Venture Court, Waterside Business Park, Valley Way Enterprise Park, Swansea, SA6 8QP

	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	**20th February 2015** **Signed:**