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:** 1. **Iain Tulley – Chief Executive Avon & Wiltshire Mental Health NHS Trust Jenner House Langley Park Estate Chippenham Wiltshire SN15 1GG**
1	**CORONER** I am Maria Voisin, Senior Coroner, for the Area of Avon.
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 12th December 2014 I commenced an investigation into the death of: • **Charlotte Emily BEVAN**, Aged **30**, and • **Zaani Tiana Bevan Malbrouck**, aged 4 days. The investigation concluded at the end of the inquest on 19th October 2015. The conclusion of the inquest for Charlotte was that she died due to 1a) Multiple Injuries with *Section 3* of the Record of Inquest Form reading as follows: Charlotte Bevan had schizophrenia and was under the care of the mental health service. On 28th November 2014, she gave birth to her daughter at St Michaels Hospital, after which her mental health began to deteriorate. Charlotte left the hospital unnoticed on the Tuesday 2nd December 2014 at 20.36hrs she walked straight from the hospital to the cliff top at the Avon Gorge. At the time she left the hospital she was suffering with a psychotic relapse that had not been diagnosed. Her body was recovered from the base of the cliff at the Avon Gorge on 3rd December 2014, her death was confirmed at 21.17hrs. The narrative *conclusion* for Charlotte I found based on the evidence was as follows: **Charlotte had schizophrenia, and was under the care of the mental health service. In early 2014 she became pregnant. There was a failure by her care coordinator who was managing Charlotte from July 2014 to develop a therapeutic relationship with Charlotte during this high risk period and to involve a psychiatrist in her care and treatment. There was a failure to hold a multidisciplinary team meeting to develop a care plan for Charlotte at all, but especially when concerns were raised by the midwives during her pregnancy, and later when it was known that she had stopped taking her Risperidone, (a fact which was reported on 14th November 2014). In addition there was a failure to arrange a face to face meeting with a psychiatrist and Charlotte when she stopped her Risperidone, which was a missed opportunity in managing Charlotte's care. Once Charlotte gave birth on 28th November 2014 her mental health began to deteriorate and she suffered a relapse which should have been diagnosed and managed appropriately by those responsible for her mental health. That failure was contributed to by the fact there was no plan. Charlotte was therefore very unwell when she left the hospital unnoticed with her daughter and went to the cliff top at the Avon Gorge on 2nd December 2014, her intention is unclear but she was found dead at the base of the cliff. That chain of failures contributed to Charlotte's death.**

	In relation to Zaani her cause of death was recorded as 1a) Head Injury. *Section 3* of the Record of Inquest form read as follows: Zaani Bevan-Malbrouck was born at St Michaels Hospital on 28th November 2014. On 2nd December 2014 she was taken from the hospital by her mother who had schizophrenia and was at the time suffering with a psychotic relapse that had not been diagnosed. Her Mother took her straight to the cliff top at the Avon Gorge, her body was recovered on 4th December 2014 amongst shrubbery growing from the cliff face, about 40 feet from the base of the cliff. Her death was confirmed at 15:02 hrs. And the *conclusion* as to death of Zaani based upon the evidence was a narrative which read as follows: **Zaani was 4 days old when she was taken by her Mother from St Michaels Hospital to the cliff top at the Avon Gorge. Her Mother had schizophrenia and was suffering with a relapse following her birth. Her Mother's intention is unclear but Zaani was found dead on the cliff face on 4th December 2014. Her death was contributed to by a chain of failures in her Mothers care.**
4	**CIRCUMSTANCES OF THE DEATH** These are explained within section 3 above but briefly Charlotte who had a history of schizophrenia gave birth to Zaani on 21st November 2014. Charlotte's mental health deteriorated and on 4th December she left the hospital with Zaani and walked to the cliff top at the Avon Gorge. Both Charlotte and Zaani's bodies were found subsequently.
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 not stated in evidence - that in all cases when a lady with a known mental health condition becomes pregnant that there is a multi-disciplinary team meeting to include all or some of the following professionals: GP, midwife, obstetrician, consultant psychiatrist, care co-ordinator, social services; and any others to be deemed appropriate. It was not stated in evidence - that and an appropriate care plan involving all agencies and professionals is drawn up and then widely circulated to those professionals who are involved with the care and treatment of the patient. That group to include; GP, midwife, obstetrician, consultant psychiatrist, care co-ordinator, social services; and any others to be deemed appropriate.
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. I would ask that you look into taking steps in relation to ensuring that there are multi-disciplinary meetings in all cases with an appropriate care plan which is then widely circulated.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 29th December 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 – the family, University Hospitals Bristol NHS Trust and to the LOCAL

	SAFEGUARDING BOARD. 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	**27 October 2015** **M. E. Voisin**