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. **Avon & Wiltshire Mental Health Partnership NHS Trust** 2. **Dorset Healthcare University NHS Foundation Trust** 3. **NHS England**
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 28th July 2017 I commenced an investigation into the death of **Rebecca Jay ROMERO**, aged **15 years**. The investigation concluded at the end of the inquest on 13th December 2017. The medical cause of death was given as: Ia Hanging The conclusion was: Accidental death contributed to by neglect
4	**CIRCUMSTANCES OF THE DEATH** Rebecca Romero died on 19th July 2017 at her home address. She had been found in the bathroom with a ligature around her neck and she died from the injuries sustained. Rebecca had been discharged from a psychiatric unit on 14th July 2017 and was under the care of the community team at the time of her death. She had not been seen since her discharge. Rebecca had a long history of self harm and mental health problems; she was described as appearing very vulnerable with very few factors of resilience. In June 2016 she began using ligaturing as a means of self harm. It was agreed by a number of witnesses that that elevated Becky's risk. On 10th June 2017 she was admitted to Pebble Lodge Adolescent Unit in Dorset as there were no beds for her in the local area of Bristol at the Unit called Riverside. On 6th July she was released for a period of leave; what in fact transpired was she never returned to Pebble Lodge after this period of leave. On 14th July there was a discharge meeting and a community care package was put into place. I was told that the original plan was to arrange to transfer Becky to Riverside but as there was no place available attempts were made to discharge her to Riverside as a day placement patient. Unfortunately there were no day placements available either and therefore a community care package was put into place. One witness described the community care package as "it just didn't feel very comfortable." Furthermore the evidence at the inquest from NHS England was at the time of Becky's

	discharge that a day patient placement was available at Riverside. An independent witness also gave evidence at the inquest and said he was concerned about the length of time that Becky was without a medical review and that post discharge was at a very high risk time. He stated that the amount of contact from the 6th July to the time of her death was not acceptable and that the plan to see Becky once a week following her discharge was not sufficient. A number of other points were raised at the inquest as follows: • In relation to the transfer from Pebble Lodge to Riverside it appears that a Form 1 was submitted to Riverside on 15th June but that the referral was closed on 6th July. There appeared to be confusion by some as to whether this was being followed up. • The community care plan that was in place from 14th July had no dates for tasks to be completed or for meetings to take place, by way of example at the time of her death a medical review appointment was still not in the diary. • Different people described Becky's risks in different ways, terminology such as low, medium or high were used to describe her risk but others used significant or low and even on the date of discharge her risks were described in different ways. • Part of the care plan was for there to be communication by text with Becky up until the time of her death there was only one text sent which was effectively confirming an appointment for after her death and simply stating "how are you". I was told that there is no current training or guidance given to staff. • This case highlighted some of the difficulties in transferring children to an in-patient unit out of the area and then arranging to transfer them back to the area.
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) In this case there was confusion as to whether on an in-patient transfer there should be a Form 2 to go alongside the Form 1 procedure. As well as clarifying this process with all providers concerned consideration should be given that a clear documented process is put in place for in-patient transfers so that all those involved understand clearly the situation and the decision made in relation to the patient. (2) Consideration should be given to ensuring that all care plans are time specific so that dates of meetings or dates for tasks to be completed are set at the time of the meeting so again expectations are managed and everyone knows exactly what the plan is and when actions will occur. (3) That the issue of inconsistent terminology when assessing risk is reviewed to ensure a consistent approach. In this case there were a number of different phrases and grading's used to determine the deceased's risk. (4) That consideration should be given to training and/or guidance issued for staff communicating with young persons by text or any means of social media. (5) Consideration should be given to reviewing whether there ought to be guidance issued when managing children who go out of area for psychiatric in patient care and further guidance issued in the management of children when returning to their local area when they have been an in-patient out of area. Whether certain steps should be taken to ensure best practice and a consistent approach e.g. risk assessing; face to face meetings; robust care planning; parental involvement; how best to re-integrate back into the local area/team.
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 2nd February 2018. 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 other Interested Persons – family, Off The Record. I have also sent it 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	**13th December 2017** **M. E. Voisin**