REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Hospital Director, Raglan House.** **2. Chief Executive, Cambian Group.**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 the 27 September 2017, I commenced an investigation into the death of Ms Natasha Ford. The investigation concluded at the end of the jury inquest on 24 January 2018. The conclusion of the inquest was a short narrative conclusion of: Taking all of the evidence into account, the jury believe the cause of Natasha Ford's death; by placing a plastic bag over her head, secured by a shoelace, to be misadventure causing her to pass away on the 20th September 2017 The cause of death was: 1a Hypoxic Brain Encephalopathy b Asphyxial Cardiac Arrest c Suffocation
4	**CIRCUMSTANCES OF THE DEATH** i) Miss Ford was a previous patient at Raglan House in Smethwick which is a 25 bed mental health hospital designed to provide an environment which promotes mental health recovery for women. ii) She was readmitted to Raglan House on 4th May 2017 under Section 3 of the Mental Health Act 1983 (amended 2007). She struggled to live independently and her condition declined. iii) Ms Ford had a complex medical history and a diagnosis of: • Borderline type of Emotionally Unstable Personality Disorder • Asperger's Syndrome (Autism Spectrum Disorder, high functioning) • Dependent and Anxious/Avoidant Personality Traits • Substance Misuse iv) During her stay she exhibited volatile behaviour initially and with the

	support of staff she began to make progress. There were incidents of self harm and also evidence of aggressive behaviour. v) On the 19 September 2017 at around 02.30am, she found in her room with a plastic bag over her head which had been tied round using shoe laces. She was taken to City Hospital in Birmingham and despite medical treatment she sadly died on the 21 September 2017.
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. Evidence emerged during the inquest that there was a previous incident on the 27 July 2017 where she had placed a plastic bag over her head. Plastic bags were then restricted for a short time and then blanket restrictions were removed. This was due to a change in policy in procedure and in line with reducing restrictive practice policy and procedure.
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. 1. I note that blanket restrictions to access plastic bags to safeguard patients have now been revisited and the policy updated to reflect this from October 2017. However I have concerns that it still remains unclear the length of time blanket restrictions will remain in place and national guidance suggests that monthly reviews should take place. 2. You may wish to consider further reviewing the guidance and also confirm whether plastic bags and similar items are restricted for all patients notwithstanding their individual risk assessments.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 9 April 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 Interested Persons; Family. 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	**13 February 2017** **Mr Zafar Siddique** **Senior Coroner** **Black Country Area**