ANNEX A

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:** **The Chief Executive ABMU Health Board**
1	**CORONER** I am Ian Boyes, Assistant Coroner, for the coroner area of South Wales Central
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 concluded an inquest on 26th February 2019 into the passing of Mr Keith Heatley. The medical cause of death was *1a. Drowning and the conclusion of the inquest was an open conclusion.*
4	**CIRCUMSTANCES OF THE DEATH** I find the fact that Mr Heatley was admitted voluntarily to hospital on 1st May 2018 and thereafter was transferred to Ward 14 on 3rd May 2018. I find that upon admission that he needed urgent admission and in [redacted] view which I accept that at the time of admission on 1st May 2018 he was considered a high risk of suicide, potential risk to his wife and possibly psychotic. I find the fact that during the time Mr Heatley remained on Ward 14 he enjoyed various amounts and degrees of leave from the hospital grounds. This varied between leave within the hospital grounds and leave outside the hospital grounds with his family. I find that there was a lack of documented evidence of multidisciplinary decision-making and planning of Mr Heatley's leave from the ward. I find that the time of writing the serious incident clinical review there was no policy guidance within the mental health and learning disability delivery unit regarding leave for informal patients. I find as a fact that although multidisciplinary team meetings were held on the 8th and 15th of May they were not documented directly in the clinical notes but were instead documented in pro formas intended to be added to the clinical record. I accept the evidence of [redacted] that there was a lack of consistent recording of MDT meetings within the clinical notes particularly for the 8th and 15th of May 2018. I find as a fact that there is no evidence of anyone agreeing or authorising leave for Mr Heatley on 18th May 2018. I find as a fact that even if there was a decision made to grant and authorise leave Mr Heatley on 18th May 2018 there was no clinical review of him prior to him leaving the

	hospital that day. I find as a fact I find the fact that the risk of suicide and/or self-harm was real and ever present. In real terms this simply means that this was not a fanciful whim or suggestion. I find that Mr Heatley left the family home at some time in the afternoon of 18th May and thereafter was found in the water. I find that Mr Heatley sadly passed away as a result of drowning. I accept the medical cause of death as propounded by [redacted] which is supported by the evidence of [redacted] concerning the blood/water fluid on the lungs. It is not suggested Mr Heatley passed away as result of any other cause. There is simply no evidence before me as to how Mr Heatley entered the water. I find that I cannot be satisfied on the evidence that the conclusion of suicide is appropriate or merited. The evidence does not show a causal link between those facts as I have found in relation to the care and the passing it follows the state could not be in breach of its obligations under article 2 to protect life. **The inquest focused on the leave given to Mr Heatley as a voluntary patient, the systems in place to authorise and review the same and the support given to families upon a voluntary patient enjoying home leave.**
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) The evidence of a Consultant Psychiatrist who was a Clinical Advisor to a Significant Incident Review stated that there was a policy in England for reviewing and assessing patients who are voluntarily admitted to hospitals before they go on home leave. There is no such policy or procedure in Wales. (2) As a result of there being no policy in Wales, hospital doctors and Nursing staff are reliant on 'best practice' however this concept is not defined nor does it provide a sufficient level of guidance for patients and staff. (3) There were no or insufficient procedures in place for hospital staff to liaise with the patient's family and CPN when leave is considered to examine the preparedness of the family and whether there were systems of support in place.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 23rd April 2019. 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 family, Health Inspectorate Wales and Welsh Government, who may find it useful or of interest. 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	**26th February 2019**	**SIGNED:** **I D Boyes- Assistant Coroner** **(Electronic signature)**