	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1) NORTH STAFFORSHIRE COMBINED HEALTHCARE; AND** **2) NHS ENGLAND**
1	**CORONER** I am Emma Serrano Area Coroner for Stoke-on-Trent & North Staffordshire Coroner's Court
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 21/11/2019 I commenced an investigation into the death of Sky Louise Rollings, aged 18. The investigation concluded at the end of the inquest on 14th October 2021. The conclusion of the inquest was Misadventure contributed to by Neglect.
4	**CIRCUMSTANCES OF THE DEATH** Sky Louise Rollings suffered with Emotionally Unstable Personality Disorder ("EUPD") was sectioned under the mental health Act. She was resident at the Harplands Hospital when she [redacted] on the 8 November 2019. She passed away on the 9 November 2019 at the Royal Stoke University Hospital due to the consequences of her [redacted]. He was transferred from a Children and Adolescent Mental Health Hospital ("CAMHS"), Huntercombe Hospital, to the Acute Adult Unit at the Harplands Hospital on the 4 November 2019
5	**<u>CORONER'S CONCERNS</u>** 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. – During the inquest evidence was heard about the differences in the way CAMHS Hospitals and Adult mental Health Hospitals approached the care of the patients on their wards. When hearing evidence during the inquest it was established that when a child turned 18, and was a patient on a Mental health ward, once transferred to an adult Mental Health Hospital they would immediately be treated in accordance with the adult provisions. It was accepted that there is no provision there is currently no one in-patient provision for people between the ages of 14-25. It was also accepted that simply because a child becomes 18 does not mean that they are an adult. The lack of this provision in a mental health in-patient setting leads me to conclude that there is a risk of further deaths resulting.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you NHS ENGLAND AND NORTH STAFFORSHIRE COMBINED HEALTHCARE and/or 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 17/12/2021. 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: 1. The Family Of Sky Louise Rollings; a) [redacted] (mother); and b) [redacted] (father); and 2. The Huntercombe Group Limited; and 3. The CQC. I am also under a duty to send the Chief Coroner a copy of your response and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	16/10/2021 Signature Emma Serrano Area Coroner **Stoke-on-Trent & North Staffordshire Coroner's Court**