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 of the Cwm Taf Morgannwg University Health Board**
1	**CORONER** I am David Regan, Area 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** A Coronial investigation was commenced on 17th March 2018 into the death of Manon Edie Jones. The Investigation concluded at the end of the inquest which I conducted on 17th – 28th January 2022. The conclusion was a narrative conclusion and the medical cause of death was 1a. Hanging. 2. Depression
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as :- Manon Edie Jones, aged 16, suffered depression and emotional dysregulation. Her behaviour was impulsive and she had a significant history of self harm. Her mental health deteriorated from late February 2018 when she concealed an overdose and a knife. On 5th March 2018 she used a [redacted] knife to cut herself and required to be disarmed by the police. She was admitted for the night to the University Hospital of Wales where she was subject to continuous observation for her safety and transferred to the Ty Llidiard Unit with 3 escorts. Her observation levels were reduced to 15 minute observations on the night of her arrival at Ty Llidiard and her admission to Enfys ward. The reasons for this were not recorded. Shortly after 21.10 on 7th March 2018 staff levels on the ward fell as staff left it to respond to an alarm. At 21.18 Manon was found by

	staff [redacted] She could not be revived. In light of her history of impulsive actions it could not be determined whether she intended to end her life. The narrative conclusion which I returned was: Manon Jones died from ligaturing while suffering a mental health episode in circumstances where she ought to have been subject to continuous 1:1 observation pending further assessment. The Inquest focused upon:- 1. The provision of community care in the week leading up to the admission 2. The adequacy of risk formulation upon and after admission 3. How that risk informed the care and treatment planning including levels of observation and the placement of Manon in a bedroom with ligature points 4. Staffing levels 5. The assessment and engagement of Manon while a patient at Ty Llidiard 6. The effectiveness of the resuscitation.
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 clinicians assessing Manon on admission to Ty Llidiard did not have available to them the records of her care made in the community by the Crisis team, the Community Intensive Treatment team or the University Hospital of Wales (2) The Clinical records in the Ty Llidiard Unit were not all entered contemporaneously in a single clinical record (3) The absence of a single in and outpatient clinical record impaired the ability of the clinicans at the unit on admission to be able to assess Manon, fix a safe levels of observations, and safeguard her.
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 18th March 2022. 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 who may find it useful or of interest. HeaIth Inspectorate Wales, Welsh Government, Medical Director of Cwm Taf University Health Board. Medical Director of Cardiff and Vale University Health 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	**28th January 2022** **SIGNED:** **D Regan** **Area Coroner**