REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive Officer, Dorset Healthcare University NHS Foundation Trust, Sentinel House, Nuffield Industrial Estate, Nuffield Road, Poole BH17 0RB
1	**CORONER** I am Andrew Bridgman, Assistant Coroner, for the coroner area of South Manchester
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 01.03.22 an investigation commenced into the death of Lauren Elizabeth Bridges who died on 26.02.22, aged 20 years. The inquest concluded on 01.09.23. **The medical cause of death was** 1a) Hypoxic brain injury 1b) Cardiac arrest 1c) Hanging injury **The conclusion of the jury was** *Lauren Elizabeth Bridges ended her life by ligature. This was misadventure with Lauren not intending to commit suicide.* *Missed opportunities for moving Lauren closer to home with acute and PICU beds available during significant periods between July 2021 and February 2022 at St. Ann's, Seaview and Haven wards, contributed to increased incidents and her death.* *The prolonged stay in a PICU placement in Priory Cheadle led to iatrogenic deterioration. This was prolonged by a delayed discharge. There was inadequate communication about Lauren from Dorset Healthcare NHS Trust to relevant parties, and there was insufficient communication about Lauren from Priory Cheadle to relevant parties.* *Dorset Healthcare NHS Trust did not recognise the exceptional circumstances of the effects on Lauren being in an out-of-area placement over 260 miles away from home.*
4	**CIRCUMSTANCES OF THE DEATH** Lauren lived in Bournemouth. From March 2020 Lauren had been an in-patient, detained under section 3 of the Mental Health Act 1983. In January 21 Lauren was admitted to a Rehabilitation Unit, at The Priory, Dorking, as an Out-of Area patient. This placement was commissioned by Dorset CCG (as it was then – now Dorset ICB). Dorking is just over 100 miles from Bournemouth. In about mid-June 2021 Lauren's mental health deteriorated and it was determined on 01.07.21 that Lauren needed to be transferred to a Psychiatric Intensive Care Unit to keep her safe. On 23.07.21 Lauren was transferred to Pankhurst Ward PICU, The Priory, Cheadle. Again, Lauren was an Out-of-Area patient at a distance, now, of some

	260 miles from home. This placement was commissioned by Dorset Healthcare NHS Trust. Lauren was ready for step-down from the PICU by 02.09.21. The plan being to seek an acute bed, at or closer to home, while a suitable Rehabilitation Unit was found. Lauren remained in the PICU, at The Priory, Cheadle for the next 5 months, until her death on 26.02.22 following a ligaturing incident on 24.02.22. Over that time Lauren's mental health deteriorated, with an increasing number of incidents of self-harm. A major factor in Lauren's deterioration was the distance from her home and family.
5	**CORONER'S CONCERNS** During the course of the inquest it was apparent that Dorset Healthcare NHS Trust's standard of record keeping was inadequate. Among other things, 1. Lauren's name dd not appear on the Out-of-Area Hospital Overview document until 19.11.21 and then she was listed in as being in an acute bed not a PICU. 2. There was a complete absence of records of purported discussions with regard to allocating/denying Lauren one of the many beds available over the 5 months following her readiness for step-down to a rehabilitation unit and readiness for repatriation to a local bed in the interim. During the course of the inquest Dorset Health made the following admission, *Dorset Healthcare NHS Trust have admitted that there were shortcomings in its systems for recording the identity and relevant circumstances of its out of area patients, and in its processes for assessing those patients when a bed becomes vacant. As a result, there may have been missed opportunities to offer Lauren a bed.* Dorset Healthcare were unable to provide a witness to deal with this issue and, having recognised the seriousness of these omission, stated via correspondence an intention to carry out a further review upon conclusion of the inquest. 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, a) the omission to update the Hospital Overview timeously and correctly. b) it can be inferred from the absence of any documentation regarding discussions about Lauren's repatriation to an available bed that no such discussion took place.
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. 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 namely, who may find it useful or of interest. 1. Lauren's family 2. The Priory 3. Dorset ICB 4. Bournemouth, Christchurch & Poole Council 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	**Dated this 19th day of September 2023**  **Andrew Bridgman** **HM Assistant Coroner**