Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Southern Health Foundation Trust** **2 Chief Coroner - PFD Reports**
1	**CORONER** I am Mrs Rachel Spearing, Assistant Coroner for the coroner area of Hampshire, Portsmouth & Southampton
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 12 January 2022 I commenced an investigation into the death of Dean John Mark Anthony BRAY aged 47. The investigation concluded at the end of the inquest on 11 November 2024. The conclusion of the inquest was that: Mr Dean Bray died of Acute Heart Failure on the 29th December 2021 whilst in the seclusion room on Hamtun Ward where there was a failure to adequately act upon and escalate Dean's high respiratory rate by nursing staff over the 28th and 29th December 2021
4	**CIRCUMSTANCES OF THE DEATH** Mr Dean Bray died of Acute Heart Failure on the 29th December 2021 whilst in the seclusion room on Hamtun Ward where there was a failure to adequately act upon and escalate Dean's high respiratory rate by nursing staff over the 28th and 29th December 2021 Narrative Conclusion The Jury's conclusion is Natural Death contributed to by Neglect. There was a gross failure to escalate Dean's deteriorating physical presentations on 28th December after 21:43 up until 08:00 on 29th December 2021, based on inadequate monitoring of Dean's physical health and a lack of recognition of Dean's medical emergency which, on the balance of probabilities but for the gross failures, Dean's life probably could have been prolonged.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) Firstly, Staff conducting 121 observations upon a patient within the seclusion room were

	unable to make a direct 999 emergency call from the observation room as no outside line was available from this handset to respond to a medical emergency. Secondly, I heard evidence from Paramedics of a delay, and difficulty with accessing the patient who was being cared for in seclusion. The most immediate access route to the ward used by secure transport services being unknown by South Central Ambulance Service and not shared with them to assist responding to a medical emergency at Antelope House.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (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 January 16, 2025. 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 **Southern Health Foundation Trust** [redacted] I have also sent it to **South Central Ambulance Service legal SCAS** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any 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 by the Chief Coroner.
9	**Dated: 25/11/2024** Rachel P-Spearing **Rachel SPEARING** **Assistant Coroner for** **Hampshire, Portsmouth and Southampton**