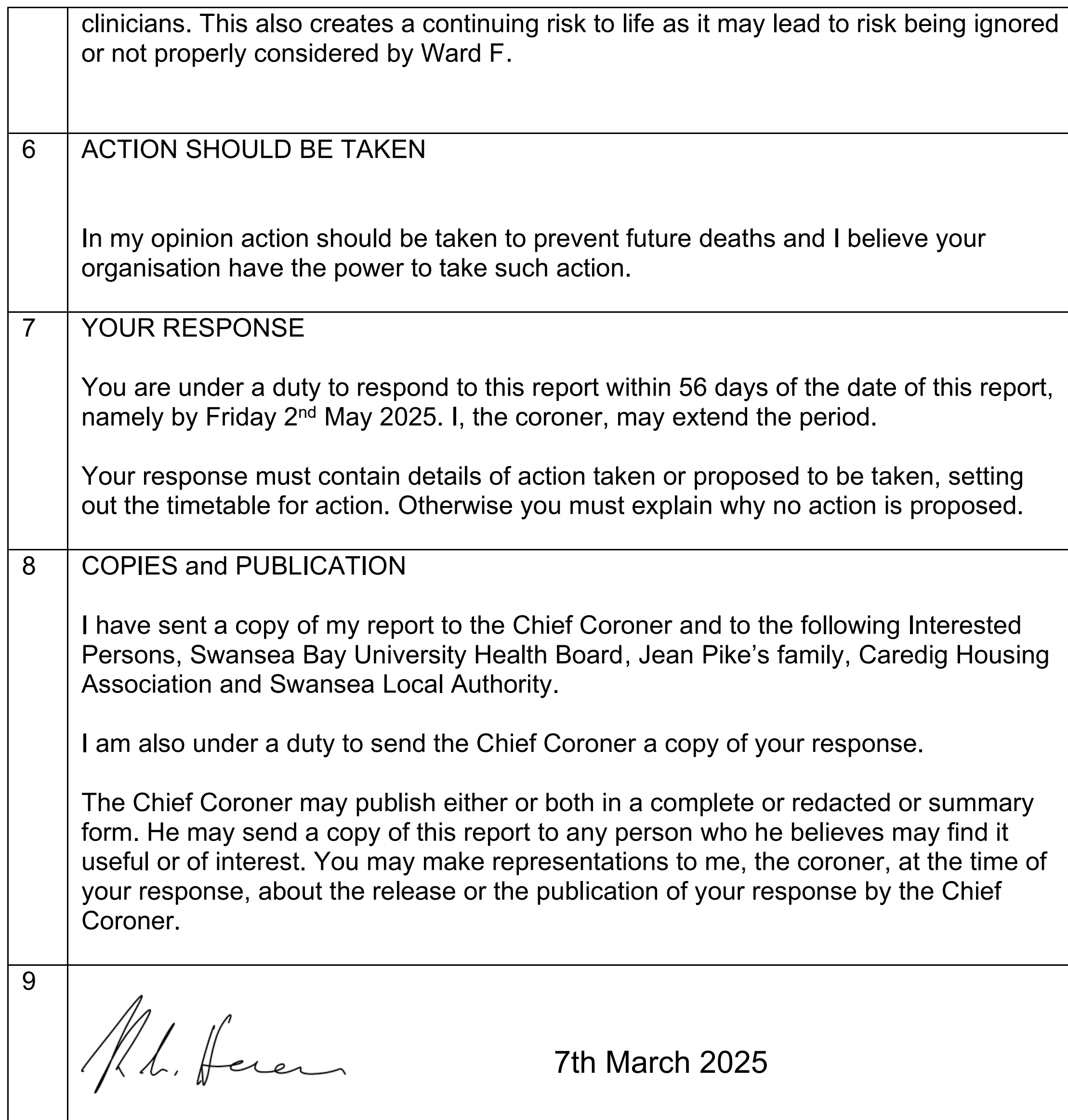
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Chief Executive Swansea Bay University Health Board 1 Talbot Gateway Baglan Energy Park Baglan Port Talbot SA12 7BR
1	**CORONER** I am Kirsten Heaven, Assistant Coroner, for the coroner area of SWANSEA & NEATH PORT TALBOT
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 18th February and 5th March 2025 I heard an inquest into the death of Jean Pike. The investigation concluded at the end of the inquest on 5th March 2025. The medical cause of death was: 1a Hanging The conclusion of the inquest was a narrative conclusion as follows: Jean Pike was a vulnerable women aged 54 at the time of death and had a diagnosis of Emotionally Unstable Personality Disorder and suffered from a depressive illness. Jean resided in supported accommodation and was under secondary mental health care. In the three months prior to her death Jean's mental health deteriorated and she engaged in serious self-harm to manage her suicidal thoughts. At this time all those involved with Jean knew she was experiencing suicidal thoughts and was expressing an intention to hang herself and was impulsive. Jean had two hospital admissions in the three weeks before her death and during this time support staff at Jean's accommodation and Jean's care co-ordinator were clearly communicating to the acute hospital where Jean was admitted on both occasions that they could not keep Jean safe in the community in her supported accommodation and that they were concerned that Jean was going to hang herself. Seven days before Jean's death a decision was taken by a consultant psychiatrist to discharge Jean from hospital nine hours after she had been admitted and at time when Jean was still actively experiencing suicidal thoughts. This decision was taken without any consultation with the professionals involved with Jean and there was no risk assessment of Jean's risk of suicide undertaken by the consultant before Jean was discharged. I find that these actions including the decision to discharge Jean from hospital constitute a gross failure to provide Jean with basic medical attention which she obviously needed and that this contributed to Jean's death. On the day of her death Jean experienced a

	mental health crisis at her supported accommodation and was threatening to hang herself. This was known to support staff at Jean's supported accommodation and Jean's care co-ordinator but despite this an inadequate safety plan was put in place to safeguard Jean. Jean was left unattended for between 20 – 45 minutes during which time Jean took her own life by hanging. I find that the failure to put in place a robust safety plan and leaving Jean unattended constitute a gross failure to provide Jean with basic medical attention which she obviously needed and that this contributed to Jean's death. I find that Jean took her own life and that she intended to do so, and that Jean's death was contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** On 18 May 2022 Jean Pike was stating that she was suicidal and intending to hang herself. Jean Pike was left unattended and unobserved for between 20 – 45 minutes. Jean Pike was then found suspended in her supported living accommodation on 18 May 2022 and declared deceased at 14.27.
5	**CORONER'S CONCERNS** During the inquest the evidence revealed matters giving rise to a 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 make a report under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. I am concerned that Jean was discharged from Ward F of Neath Port Talbot Hospital on two occasions shortly before her death by a consultant psychiatrist and that prior to the decision to discharge on both occasions there was no multi-disciplinary meeting between the consultant on Ward F and the professionals directly involved in caring for Jean in the community about Jean's mental health and the risks she posed to herself in the community. This was in circumstances where the consultant knew before the decisions to discharge that these professionals, which included Jean's care co-ordinator, were clearly stating that they were extremely concerned about Jean's mental health and that they did not consider that they could keep Jean safe in the community and that they thought that Jean would hang herself in the community – which is in fact what happened in this case. I am particularly concerned by the evidence I heard from Jean's care co-ordinator that care co-ordinators are rarely if ever consulted by consultant psychiatrists in Ward F of Neath Port Talbot Hospital before a decision is made to discharge a patient/person under secondary mental health care. This issue was not identified by Swansea University Bay Health Board ('SUBHB') in their internal investigation into Jean's death. This investigation found that "*there is evidence of regular and effective communication between support staff, community staff and hospital staff*". The above finding of SUBHB's internal investigation raises a concern that critical lessons have not being identified and learnt by SUBHB from Jean's death about the importance of multi-disciplinary decision making in clinical care and risk management and the importance of including care co-ordinators and professionals in the community before a decision is taken to discharge a patient from Ward F. This creates a continuing risk to life as it may lead to risk being ignored or not properly considered by Ward F. I am also concerned that if there is a lack of clarity or a reluctance in Ward F at the consultant level to engage with care co-ordinators and professionals in the community (and before decisions are made to discharge) there is a risk that the concerns of the professionals managing a patient/person under secondary care will not be adequately considered in the decisions made by Ward F



	clinicians. This also creates a continuing risk to life as it may lead to risk being ignored or not properly considered by Ward F.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe 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 Friday 2nd May 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, Swansea Bay University Health Board, Jean Pike's family, Caredig Housing Association and Swansea Local Authority. 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	7th March 2025