REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Black Country Healthcare NHS Foundation Trust** **2. Family- Represented by FBC Manby Bowdler Solicitors**
1	**CORONER** I am Mr Zafar Siddique, Senior Coroner for the Black Country.
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 https://www.legislation.gov.uk/uksi/2013/1629/part/7
3	**INVESTIGATION and INQUEST** On 4 April 2023, I commenced an investigation into the death of Ms Shannon Lee Jordan born on the 21 May 2001 who died on the 1 March 2023. The investigation concluded at the end of the inquest on 23 October 2025. The inquest was heard before a Jury and the conclusion at inquest was Shannon's death was self-inflicted by external neck compression by ligature strangulation compression. It is impossible to determine Shannon's exact intent. The medical cause of Shannon's death was recorded as 1a External neck compression 1b Ligature strangulation compression
4	1. On 31st January 2023 Shannon had been taken to New Cross Hospital, Wolverhampton A&E by ambulance after her mental health had deteriorated and she said that she had been planning to run in front of cars. 2. Initially, Shannon had been offered support from the Home Treatment Team. However, she had refused this as she felt that she would have harmed herself before she had seen the HTT. There were no beds available in the district and Shannon remained in hospital. 3. On 2nd February 2023 Shannon was transferred to Abbey House, Hallam Street Hospital as a voluntary patient and placed on 1:1 observation awaiting a doctor's review. Shannon complained of hearing voices telling her to tie a ligature and she was banging her head against a wall. She attempted to abscond from the ward and she tied a loose ligature around her neck that was removed by staff. 4. On 5th February 2023 Shannon was placed under Section 54 MHA after she demanded to self-discharge from the hospital. Staff believed that she would be a danger to herself. On 7th February 2023 her Consultant Psychiatrist detained her under S3 MHA and she was placed on 1:1 observation.

	5. On 14th February 2023 Shannon managed to tie a ligature [redacted] whilst on 1:1 observation and sent a text message to another patient on the ward to tell her what she had done. The staff member observing her managed to raise the alert. 6. On 21st February 2023 at 09.46 she is briefly placed on 15-minute observations. However, at 13.30 hours Shannon tied a ligature around her neck her again. 7. After further review and a request Shannon was placed on fifteen-minute observations on 1st March 2023. Shannon had spoken to the ward manager on 28th February and asked to move to 15-minute observations. The ward manager emailed her consultant Psychiatrist who had agreed the change in observation levels. 8. The observations were allocated to Health Care Assistants with one-hour slots. Each HCA was asked to perform observations on the hour, quarter past, half past and quarter to the hour as per the observation recording form: Level 2. 9. On 1st March 2023 HCA, [redacted] was tasked with observations between 11.00 – 12.00 hours. The second HCA, [redacted] was tasked to complete the checks between 12.00 - 13.00 hours. 10. There is CCTV footage that covers the corridor where Shannon's room was located. Shannon leaves her room at 11.21 hours and returns to the room at 11.23 hours. This is the last time that Shannon is seen alive. [redacted] only completes one check at 11.19 hours but signs and completes the observation sheet confirming all four checks have been completed. He is seen on CCTV walking past Shannon's room in one direction at 11.42 hours and back in the opposite direction at 11.47 hours without conducting further checks. 11. [redacted] completes his first check for Shannon at 12.10 hours. When he looks into Shannon's room he cannot see her due to how she has positioned herself on the floor against the door. The HCA then spends the next ten minutes going backwards and forwards checking different locations and he is unable to find Shannon. He tries to open her door, but he is unable to do so and he summons help with a buzzer. 12. Staff come to assist him and the bedroom door (anti-barricade door) is opened on to the corridor and staff members find Shannon unresponsive and start to provide CPR. An ambulance was called, paramedics and a doctor attended. The ambulance crew tried to resuscitate her but sadly she is pronounced deceased at 13:10hours
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 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. – 1. During the course of the inquest, I heard evidence that Ms Shannon Lee Jordan was under observations to be performed at 15-minute intervals. 2. My concern is that despite a new Policy being implemented by the Trust, which specifies that 15-minute observations should be recorded via the electronic tablet at 15-minute intervals. There remains, some confusion and lack of clarity whether the 15-minute time interval can fall within a range of 15 to 30 minutes.

	3. There is no national standard, and each Trust can implement its own time interval for observation checks to be completed.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 22 December 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: [redacted] 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 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	**Mr Zafar Siddique** **Senior Coroner** **Black Country Area** **27 October 2025**