Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **South West Yorkshire Partnership NHS Foundation Trustof Wakefield** 2. **Copy to The Chief Coroner**rule43reports@justice.gsi.gov.uk 3.
1	**CORONER** I am **Timothy Harvey Ratcliffe**, Assistant Coroner for the Coroner area of West Yorkshire (Western)
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 5 March 2013I commenced an investigation into the death of Jane Dyson Gabbitas, aged 52. The investigation concluded at the end of the inquest on 5 December 2013. The conclusion of the inquest was that "Jane Dyson Gabbitas died as a result of ingesting alcohol and gabapentin in sufficient quantities to cause her death, having gone to a place where she would be unlikely to be easily discovered, at a time when she was resident at an open unit in which she had agreed to stay to assist her treatment for depression, and was under the care of the Intensive Home Based Treatment Team of the local NHS Trust" (the **Trust**). The medical cause of death was I(a) Combined overdose of alcohol and gabapentin.
4	**CIRCUMSTANCES OF THE DEATH** On 2 March 2013 the deceased was reported missing. A member of the public alerted the police to an abandoned car behind a pumping station off Bar lane, Ripponden, West Yorkshire. The deceased was found unconscious and, despite attempts at resuscitation, life was pronounced extinct at the scene at 18:54 hours.

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. – The SHARE accommodation unit in which Mrs Gabbitas was resident over the short period prior to her death is an open residential unit operated by the Trust and the local authority in partnership; but the Trust in this case was responsible for Mrs Gabbitas' admission and therefore it is the Trust to whom this report is addressed. I was at the inquest told that a report had been prepared within the Trust relating to Mrs Gabbitas and I was given a copy of its findings, and noted these. The following matter however was not addressed in the report. The inquest revealed a period of time on the day of her death from approximately 1.40pm to 6pm when Mrs Gabbitas was absent from SHARE, and she never returned, her body then having been discovered some distance away. Staff at SHARE were aware that she had indicated an intention to go out, but apparently were not aware of the full extent of her absence until telephoned by Mrs Gabbitas' daughter to say her mother's body had been found by police. It was not clear if there was any sign-in /out arrangement or any reception facility at SHARE to account for absences. I consider that, although I did not find that Mrs Gabbitas' death would have been prevented by earlier attention to her absence, there is a risk that future deaths may occur in similar circumstances if no action is taken to record and monitor absence,albeit informally (in keeping with the nature of care in the SHARE unit), and to react appropriately to absences which appear to be inappropriate or particularly lengthy.
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, namely by 5 February 2014. 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 Person: [redacted] 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	**12 December 2013** **…(signed) T H Ratcliffe…..** **Timothy Harvey Ratcliffe** **ASSISTANT CORONER**