Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 [redacted] Chief Executive- South West Yorkshire Partnership

1 CORONER

I am Dr Anthony Howard», Assistant Coroner for the area of West Yorkshire, Western Division

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 Third March 2020 I commenced an investigation into the death of Emma Kate DORMAN aged 46. The investigation concluded. At the end of the inquest, the conclusion of the inquest was:

Ia Asphyxia (Hanging)

I b

I c

II

4 CIRCUMSTANCES OF THE DEATH

On the 24th February, 2020. Emma Dorman, died of Asphyxiation by hanging at [redacted]Lidgett Lane, Skelmanthorpe, Huddersfield, after being allowed leave from the Priestley Unit, Dewsbury & District Hospital. The leave had been changed at the last minute due to bed availability. During the leave the deceased had not been visited by the Home Based Treatment Team as planned.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

1. That the decision of leave was dominated by the non-clinical team through the Bed Manager and clinical staff felt they could not object. The draft amended clarification still enable those not directly responsible for patient care to effect clinical management of the patient.

2. That there was no psychologist input on the ward, which had persisted for over three years prior to this incident. The only steps taken to alleviate this vacancy was to re-advertise the same post with the same level of remuneration.

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 3rd May 2021. 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] - Husband of the Deceased.

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.

Signed:

Dated: 11 - III - 21