REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive of Rotherham Doncaster and South Humberside NHS Foundation Trust** **2. The Executive Medical Director of Rotherham Doncaster and South Humberside NHS Foundation Trust**
1	**CORONER** I am Nicola J Mundy, Senior Coroner, for the Coroner area of SOUTH YORKSHIRE, EAST DISTRICT.
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 21st June 2013 I commenced an investigation into the death of DANIEL WILLIAMS, AGE 24. The investigation concluded at the end of the inquest on 2ND JANUARY 2014. I concluded that the cause of death was 1a HANGING and returned a NARRATIVE CONCLUSION as follows: In May 2013 Daniel Williams was admitted to St Catherine's Hospital following an episode of deliberate self harm by way of insulin overdose. This was on a background of psychiatric problems which developed following a diagnosis of diabetes which had profoundly effected him. During the course of his admission superficial enquiries by staff and unreliable record keeping compromised the quality and completeness of the clinical information which in turn compromised the effectiveness of the risk assessments. Poor communication exacerbated matters. All these factors served to further increase Mr Williams' significant risk of self harm. On 15 June 2013 Daniel Williams died from hanging following self application of a ligature in his room at St Catherine's Hospital.
4	**CIRCUMSTANCES OF THE DEATH** Daniel Williams had been diagnosed as suffering from Diabetes as the age of 19. This profoundly affected his mental wellbeing and also had physical implications too. As a consequence he engaged with the psychiatric services and his final admission to hospital was on the 23rd May 2013 following an overdose of insulin. Mr Williams suffered from suicidal thoughts for much of that admission and appeared to be considering alternative methods for ending his life. There were a number of risk assessments and one to one meetings, many of which appeared not to explore in any depth his suicidal thoughts and intent. On the 15th June 2013 Mr Williams hanged himself with a bedsheet by knotting one end and securing it in the door jamb to the en suite bathroom and tying the other end tightly around his neck.

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. – (1) Quality of staff training, particularly with regard to record keeping and communication. (2) The emphasis on taking a holistic approach to care and whether there is an imbalance between adopting such an approach and patient safety. (3) The absence of clear guidance for checking patients and their rooms for potential self harm items both in the rooms themselves and for items brought into the hospital. (4) The absence of a single reference sheet in the notes summarising key issues, risk factors, significant incidents and concerns readily accessible to all involved in patient care.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 28th February 2014. I, the Senior 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] of Henshaw Pratt Solicitors, the mother of the deceased [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	**6 January 2014** **Senior Coroner, South Yorkshire (East) District**