ANNEX A

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:** **1. [redacted] Community Mental Health Team, Weymouth** **2.** **3.**
1	**CORONER** I am Sheriff Stanhope Payne, senior coroner, for the coroner area of Dorset.
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 the 9th April 2013 the coroner for Birmingham commenced an investigation into the death of KEWARD GUY DOMONIC HARDING aged 27 at Queen Elizabeth Hospital. Jurisdiction was passed to me on the 18th June 2013 and the investigation concluded at the end of an inquest held at Dorchester on the 15th August 2013.. The conclusion of the inquest was that he had died of natural causes with the medical cause of death being Ia) Multiple organ failure, Ib) Dilated cardiomyopathy, Ic) Sepsis (treated) II Obesity Type III Diabetes Mellitus, Diverticulitis and Infected Cellulitis.
4	**CIRCUMSTANCES OF THE DEATH** Mr Harding had a learning disability and lived at home with his mother. He was seen by [redacted] GP on the 12th and 19th March 2013. On the second occasion he did not exhibit signs of serious physical illness but [redacted] felt that a mental health assessment should be carried out urgently. She telephoned [redacted] to discuss her concerns and to request an urgent referral and followed this up with a letter dated 20th March 2013. [redacted] advised [redacted] that an assessment would be carried out in days. It would appear that Mr Harding deteriorated over the Easter weekend and [redacted] called The Bridges Medical Centre on Tuesday 2nd April to express her concern about her son. [redacted] visited the family home that day to find Mr Harding hypoxic, hypotensive and oedematous with suspected sepsis. Mr Harding was admitted to Dorset County Hospital critically unwell and was later transferred to Birmingham on the 6th April for consideration of extra-corporial assistance and possible heart transplantation but he sadly died on the 7th April.

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** is as follows. – That an urgent mental health assessment was requested on the 19th March 2013 which had not taken place before the 2nd April 2013. If a health professional had visited the family they may have detected a decline in his physical health at a stage where active treatment could be commenced which may have prevented his death.
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 11th October 2013. 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] at The Bridges Medical Centre, 26 Commercial Road, Weymouth DT4 7DW, [redacted] at Dorset County Hospital, Williams Avenue, Dorchester, DT1 2JY. 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	**16th August, 2013** **Sheriff Stanhope Payne** **H M Senior Coroner**