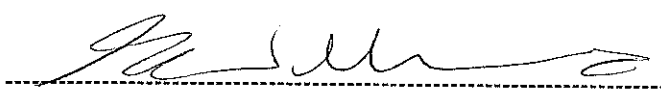
ANNEX A

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. **Worcestershire Health and Care NHS Trust** 2. 3.
1	**CORONER** I am Geraint Urias Williams, Senior Coroner, for the coroner area of Worcestershire
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 5th September 2013 I commenced an investigation into the death of Sean Christopher SEABOURNE then aged 44. The investigation concluded at the end of the inquest on 12 December 2013. The conclusion of the inquest was Mr Seabourne killed himself the medical cause of death being hanging .
4	**CIRCUMSTANCES OF THE DEATH** Mr Seabourne was suffering with recurrent periods of depression and anxiety and in August 2013 sought assistance from his GP and from your service. He was referred initially by the GP to the Community Mental Health Team who passed him on the Assessment Team with a view to a formal assessment , crisis support and thereafter either an informal admission to hospital or work from the Home Treatment Team. On the 1st September 2013 (after contact with the Crisis Support Team) he hanged himself at his place of work at Church Green in Redditch.
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) The Community Mental Health Team assessed Mr Seabourne as being a man with a definite plan to kill himself which the sought to hide from professionals. The CMHT referred Mr Seabourne on an urgent basis to the Assessment Team making it plain that he was making positive plans and that he should be seen on the same day with a view to a formal assessment to consider a voluntary admission to hospital or Crisis Support. It was stressed by CMHT that Mr Seabourne needed to be seen face to face because of

	his ability to "dissemble" and thus hide his plans to kill himself. There was no written confirmation of the CMHT duty workers view and requests. (2) The Assessment Team denied being asked to assess Mr Seabourne and although the team member acknowledged that he had been made aware that Mr Seabourne was deliberately concealing settled plans to kill himself he took the view that the matter was not urgent and contends that he was not asked to perform an assessment. The team member concerned indicated that in his judgement a request for crisis support does not require an assessment of the patient. (3) It was clear from the evidence that there was a lack of effective communication between the separate teams which comprise of Mental Health Services within the County with the Team Manager of the Assessment Team being unaware of (upon the end of the 72 hour involvement with Mr Seabourne on the part of his team) whether the CMHT would become automatically involved with onward work with Home Treatment Team. It appears that there are systemic failings in terms of communication and understanding of roles and responsibilities in respect of the patient whom everyone acknowledged was at high risk and with settled plans to kill himself. It appears from the evidence that a lack of formal communication where all details are past from team to team led to a situation where those having contact with Mr Seabourne were unaware of the real risk that he might kill himself. Had all of the concerns of the GP and original psychiatric nurse who referred Mr Seabourne been formally documented and disseminated to each of the new teams then it is likely that he would have been seen face to face and a formal assessment considering whether he should have been admitted to hospital would have been undertaken. This may well have changed the outcome in this case.
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: 1. To review the lines of communication between teams. 2. To consider whether referral between teams should be made or confirmed in writing.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 7th 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 Persons [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	**Signed** 

	G U Williams H M Senior Coroner	17th day of December 2013