REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Mr Edward Colgan,** Chief Executive, Somerset Partnership NHS Foundation Trust, 2nd Floor, Mallard Court Express Park, Bristol Road, Bridgwater , TA6 4RN
1	**CORONER** I am Michael Richard ROSE, Senior Coroner for the West Somerset area
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 3rd September 2012, I commenced an investigation into the death of Kevin Paul SUTTON deceased aged 57 years. The investigation concluded at the end of the Inquest on 14 November 2013. The Conclusion of the Inquest was that the deceased had met his death by suicide and the cause of death was: 1a Asphyxia 2. Huntingdon's Disease
4	**CIRCUMSTANCES OF THE DEATH** The deceased had first been referred to the Somerset Partnership NHS Foundation Trust towards the beginning of this century but the first entry recorded in your Trust records is in April 2005. Over the ensuing years he was seen on a number of occasions by a Consultant Psychiatrist from your Trust due to his continuing depression but was then thought to be low suicidal risk as a result of his Huntingdon's disease. The deceased was later admitted to Rydon Ward, Cheddon Road , Taunton where he was discharged on the 19 June 2012 to the Willows at Bridgwater but was admitted to Musgrove Park Hospital on the 26 June as he was not eating or drinking. On the 11 July 2012 he was discharged from Musgrove Park Hospital to Halcon House, Huish Close, Taunton, premises belonging to Somerset Care Limited from where on the 3 September he would take his own life. During the Inquest evidence was given by the manager of Halcon House that no care plan had been prepared, and as a consequence they were not made aware of the real suicidal risk that they faced with the deceased.

5	**CORONER'S CONCERNS** During the course of the inquest I formed the opinion that there was a risk that future deaths could occur unless care plans were prepared for any patient leaving wards under the control of the Somerset Partnership Foundation Trust, when they were being discharged to another establishment. The **MATTERS OF CONCERN are as follows:-** Failure by the Trust to provide care plans.
6	**ACTION SHOULD BE TAKEN** That there should be brought in rules making it obligatory for care plans to be prepared and lodged with any other establishment to which a patient is discharged.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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 . 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	**DATE** **SIGNED BY CORONERa**