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. South West Ambulance Service**
1	**CORONER** I am Dr Elizabeth Ann EARLAND, Senior Coroner, for the Exeter and Greater Devon 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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 15th February 2013 I commenced an investigation into the death of Roger Clive DUGGAN, Aged 61 years. The investigation concluded at the end of the Inquest on 5th March 2014. The conclusion of the inquest was Open Verdict: The Deceased was in a heightened anxiety state when he absconded from cubicle 8 in the Accident and Emergency Minors Department at the Royal Devon and Exeter (Wonford) Hospital at 00.47 hours 11th February 2013, after which, at some point, he entered the River Exe opposite Mill Lane. He also had ischaemic heart disease.
4	**CIRCUMSTANCES OF THE DEATH** 10/2/13 Wife had given him 2 x Diazepam approximately 2100-2130hrs and kept the packets in her handbag. He was in a very agitated state, pacing. Wife rang the crisis team who suggested they call 999, he said to his Wife "he wanted to get out and would not be back". After some considerable delay the Ambulance arrived and he was taken to A&E Minors RDE via ambulance late that night, but absconded from the department via main entrance at 0047hrs 11/2/13 and is shown on CCTV to leave the site shortly afterwards. An extensive search was carried out by Police in the area with no sightings. 12/2/13 Mr Duggan's body was located by a group of canoers in the water at a tributory to the River Exe, opposite Mill Lane Exeter, his body was recovered by joint emergency services and confirmed deceased at 1430hrs. Police happy no suspicious circumstances. Deceased's glasses were found, intact in his pocket. Wife states he always wore them and believes he took them off purposefully.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) Whilst it was apparent in evidence that matters had reached fever pitch at Mr Duggan's home, The Lindhay, The Old Farmhouse, Brampford Speke, on the evening of the 10th February 2013 as he reached a severe anxiety state. The family were firmly of the view the initial calls to Ambulance Control were not treated sufficiently seriously (despite the family being advised to do so by the Crisis Team). An ambulance visit only materialized after a further call to the Crisis Team and the latter's instruction to Ambulance Control to attend. It appears that staff lacked the necessary training to deal with Mental Health Crisis. After subsequent arrival at the Royal Devon and Exeter Hospital (Wonford), Accident and Emergency Department, later that night 10th February 2013 Mr Duggan absconded only to be found deceased in the River Exe at 14.30 hours 12th February 2013.
6	**ACTION SHOULD BE TAKEN** In my opinion there is a case for examination of the staff response to [redacted]s calls on 10th February 2013 and an assessment of whether further training in the evaluation of psychiatric emergencies is required.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 2nd June 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] the Deceased's next of kin. I have also sent it to Mr Duggan's General Practitioner, [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	**Inquest Date: 5th March 2014. Date of Report: 7th April 2014.** **……** Dr Elizabeth A Earland MB.Ch.B.,D.A.,Dip.Law,L.P.C,Hon.LLD HM Senior Coroner