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. **Kent and Medway NHS and Social Care Partnership Trust** 2. **Maidstone and Tunbridge Wells NHS Trust**
1	**CORONER** I am Patricia Harding, senior coroner, for the coroner area of Mid Kent and Medway
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 27th August 2013 I commenced an investigation into the death of Peter Franklin dob 14.09.1945. The investigation concluded at the end of the inquest on 29th and 30th April 2014. The conclusion of the inquest was that Peter Franklin killed himself whilst suffering from depression. The medical cause of death was multiple injuries
4	**CIRCUMSTANCES OF THE DEATH** Peter Franklin suffered with mental health difficulties for many years. He had previously been admitted to hospital following an overdose in June 2013. Following his discharge from hospital in July 2013, Peter Franklin attended Accident and Emergency Departments with increasing frequency in the period leading up to his death. On the 19th August 2013 he attended the Accident and Emergency Department at Maidstone Hospital on four occasions and Priority House (mental health team) on two occasions. His behaviour was increasingly unusual throughout the day but he did not present as a suicide risk when seen by his care co-ordinator in the morning. The mental health team was informed of the circumstances of his attendances at Accident and Emergency. On the evening of the 19th August 2013, when he attended Accident and Emergency on the fourth occasion, he attempted to jump from a motorway bridge at Junction 5 on the M20 after discharge from the hospital and was prevented from doing so by the taxi driver who was returning him home. Peter Franklin was taken back to hospital where a request for a mental health assessment was made to the CRISIS team. An assessment did not take place although one was required because the psychiatric nurse did not think it fair to make Peter Franklin wait at the hospital until she was able to attend. The psychiatric nurse told the hospital nurse to call his daughter to take him home. She did not inform the nurse that that Mr. Franklin may be a suicide risk or that an assessment was required but would entail him waiting at the hospital. Peter Franklin was dropped off at his home address by his daughter who was unaware of the detail of that which had transpired. Within approximately ten minutes of leaving him at his home address Peter Franklin drove to the motorway bridge that he had earlier attended and jumped to his death

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) There was confusion in the terminology used between nursing staff or doctors and the CRISIS team when out of hours calls were made such that it was not clear between parties whether a referral, advice or assessment was sought (2) Relevant information/advice was not provided by the CRISIS team to parties who had made referrals (3) Mr. Franklin's GP would have initiated a multidisciplinary team meeting to address the increasing frequency of attendances at hospital had he been aware of the recent hospital admission, the subsequent involvement with the mental health team and the attendances at A&E. The documentation from both hospital and mental health trusts was subject of significant delays such that none of the letters to the GP sent by either trust from July onward arrived with the GP before Mr. Franklin died
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 the 16th July 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	**19th May 2014** [signature]