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. **RACHEL NEWSOM, Chief Executive, Coventry & Warwickshire Partnership NHS Trust, Trust Headquarters, Wayside House, Wilsons Lane, Coventry CV6 6TR**
1	**CORONER** I am DAVID OSBORNE, Assistant Coroner, for the Coroner area of NORFOLK
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 29 NOVEMBER 2013 an investigation was commenced into the death of SOL HADHASSEH (FORMERLY KNOWN AS JUDITH ELVIRA SARKADY), AGED 47. The investigation concluded at the end of the inquest on 12 JUNE 2014. The conclusion of the inquest was Sol Hadhasseh killed herself, the medical cause of death being 1a: Tramadol Toxicity.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death were that Sol Hadhasseh had been under the care of Coventry & Warwickshire Partnership Trust since 1999. She had a complex history with diagnoses of personality disorder and dissociative identity disorder. Her most recent diagnosis was of emotionally unstable personality disorder – borderline type. She had a history of self-harm and parasuicidal behaviour. She had been admitted as an in patient on 8 June 2013 under S136 Mental Health Act and was subsequently detained under Section 2. She was discharged to her home address on 19 June 2013. She continued under the care of the Trust until she moved to Norfolk in October 2013. She registered with a GP practice in Cromer. On 28 November 2013 concerns were raised for her welfare. Access was gained to her flat where she was discovered unresponsive and sadly declared deceased at the scene.
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. – I read from a report received from Sol's treating consultant psychiatrist at the Warwickshire & Coventry Partnership Trust. The consultant did not give evidence in person. In his report the consultant stated that he wrote to Sol's GP in Cromer on 14 November 2013 requesting that the GP refer Sol to the local Mental Health Trust. When giving evidence in person the GP confirmed that the letter was not received until 9 December 2013, after Sol had died. It was not known that this was the case until the GP gave evidence before me at the Inquest.

I heard at the Inquest from the Acting Deputy Service Manager of Norfolk & Suffolk NHS Foundation Trust's Access & Assessment Team. In her evidence she stated that in her experience she would have expected the Warwickshire & Coventry Partnership Trust to have made a direct written referral Trust to Trust rather then via the GP, given the complex needs and history of Sol and that this should have been planned in advance. Whilst it can not be known whether had such referral been made the outcome for Sol would have been different, I am nevertheless concerned that were a similar circumstance to arise in the future then a preventable death might occur and there is a continuing risk that other deaths could occur which could be avoided. I was therefore concerned that procedures for transferring a patient to another Trust should be reviewed by the Warwickshire & Coventry Partnership Trust.

This issue only arose in the light of the evidence given in person at the Inquest and was not apparent from the statements and reports provided prior to the Inquest. I would therefore record that it is accepted that in the circumstances which have arisen the Warwickshire & Coventry Partnership Trust ("**the Trust**") have not had the opportunity to respond to that evidence. Had the issue been apparent from statements and reports obtained then the Trust would have been asked to attend. I therefore recognise that it is possible that steps may have already been taken to review the transfer of patients who are moving area. In that event the response to this report will no doubt set out what steps have been taken.

6 **ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe you and/or 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 Friday 15 August. 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 **17 June 2014**