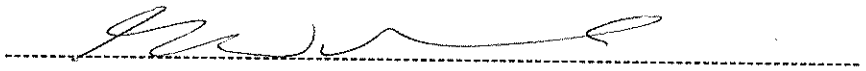
ANNEX A

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 & 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 19th August 2014 I commenced an investigation into the death of Eve Cullen then aged 52 years. The investigation concluded at the end of the inquest on 7th January 2015. The conclusion of the inquest was open the medical cause of death being unascertained .
4	**CIRCUMSTANCES OF THE DEATH** Mrs Cullen suffered from epileptic seizures following brain surgery in 2011 and had a fluctuating peri ictal confusional state. In June and July 2014 she had been an in-patient at the Queen Elizabeth Hospital in Birmingham before being discharged home. The psychiatrist at the Queen Elizabeth Hospital made a referral to the Redditch & Bromsgrove Community Mental Health Team for follow up but this was not actioned by the CMHT. On the 14th and 15th of July 2014 Mrs Cullen was seen by 2 different psychiatric nurses (one at Birmingham the other at Redditch), both of whom made urgent referrals to the Redditch & Bromsgrove CMHT. Mrs Cullen was offered an appointment to see the CMHT on the 24th of July 2014. On the 17th of July Mrs Cullen went missing from her family home whilst, apparantly, in a per ictal confusional state and her body was later discovered in an alleyway on the 9th of August 2014. She had clearly been dead for some time.

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 failure to action the referral from the Queen Elizabeth Hospital (2) The failure to treat the 2 referrals on the 14th & 15th July 2014 as urgent (3) The lack of any uniform agreement as to what constitutes an 'urgent' referral I received evidence from [redacted], Clinical Lead, for the Redditch & Bromsgrove CMHT who confirmed that there was no evidence on the file that the referral on file had been actioned at all. She confirmed that (as set out in the root cause analysis which has been prepared), there is no service wide definition of what might constitute an urgent referral (nor any agreed definition of such terms as 'very urgent', 'immediate', 'routine') and further when referrals are made no suggested timeframe is recorded. She also told me that once the referral is received it is a matter for the psychiatrist as to when the patient is seen, even though the psychiatrist would not have had any contact with a new patient referred in this way. Although it is impossible to tell whether faster action may have changed the outcome in this case it seems that when 2 mental health professionals ask for an urgent referral but no action is proposed for some 8 days that this amounts to a lost opportunity to intervene and possible save the life of the patient. I would ask the Trust to consider that terms such as 'very urgent, 'urgent', 'routine' etc. should be defined with a view to there being a service wide understanding of what is expeceted in terms of timely action upon referrals that are made.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 5th March 2015 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 8th day of January 2015