	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Derbyshire Healthcare NHS Foundation Trust** **2. Derbyshire County Council** **3. NHS England**
1	**CORONER** I am an Assistant Coroner, for the Coroner Area of Derby and Derbyshire.
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 9th April 2013 an investigation was commenced into the death of Louise Sharon Henry. The investigation concluded at the end of the inquest heard between 2nd to 5th December 2014. The conclusion of the inquest was a narrative conclusion and a medical cause of death namely: 1a Aspiration pneumonitis and amphetamine excess consumption and at 2. Emotionally Unstable Personality disorder, paranoid psychosis. Narrative: Louise Sharon Henry had a long history of significant mental health problems with diagnosis of Emotionally unstable personality disorder, agoraphobia, panic disorder and probable paranoid psychosis. Following a home visit to Louise Sharon Henry on 18.2.13 by Consultant Psychiatrist from the Community Mental Health Team [CMHT] and lead professional namely a Social Worker from the Recovery Team of Derbyshire County Council [DCC], Louise Sharon Henry was discharged from mental health services provided to her from the CMHT and DCC Recovery team back to the care of the GP. The discharge process did not identify and communicate to the GP risk relapse triggers or a clear contingency plan in the event of a relapse or deterioration of Louise Henry's mental health and did not identify if there was evidence of psychotic symptoms relating to Louise Sharon Henry believing neighbours were accessing her property then urgent reassessment would be required.

	Shortly after 4pm on 1.4.13 entry was forced to Louise Sharon Henry's home at 70 Rothervale Road, Birdholme, Chesterfield by her eldest son who had become increasingly concerned for his mother's welfare due to deterioration in her mental state. Louise Sharon Henry was found deceased in her bedroom sat at the bottom of her bed on a stool surrounded by opened blister packs of medication containing Diazepam, Omeprazole, Nitrazepam, Sertraline and Ibuprofen. These blister packs indicated that Louise Sharon Henry had not been taking her medication as directed. Next to Louise Sharon Henry was pink stained vomit containing undigested ibuprofen tablets. Toxicological examination of samples taken at post mortem confirmed consumption by Louise Sharon Henry of a substantial amount of amphetamine shortly prior to death. At the time of consuming the Ibuprofen and amphetamine Louise Sharon Henry was suffering from a relapse and deterioration of her mental state, including psychotic symptoms and experiencing and responding to auditory and visual hallucinations that neighbour's were accessing her loft. Police and paramedics were called and attended the scene where life was formally pronounced extinct at 16.31 on 1.4.13 by the attending paramedic.
4	**CIRCUMSTANCES OF THE DEATH** This can be seen in summary from the narrative conclusion set out. Following a home visit to Louise Sharon Henry on 18.2.13 by Consultant Psychiatrist from the Community Mental Health Team [CMHT] and lead professional namely a Social Worker from the Recovery Team of Derbyshire County Council [DCC], Louise Sharon Henry was discharged from mental health services provided to her from the CMHT and DCC Recovery team back to the care of the GP. The discharge process of Louise Henry from the mental health services provided to her by DCC Recovery Team and CMHT just over a month before her death did not identify and communicate to the GP risk relapse triggers or a clear contingency plan in the event of a relapse or deterioration of Louise Henry's mental health and did not identify if there was evidence of psychotic symptoms relating to Louise Sharon Henry believing neighbours were accessing her property then urgent reassessment would be required. In the past when Louise Henry had experienced psychotic symptoms relating to her neighbours accessing her home she had taken overdoses and the risk of accidental or deliberate overdose was known. The lead professional had not written to the GP to inform of her discharge of Louise Henry from DCC Recovery Team. The psychiatrist had written to the GP informing them of her discharge but the letter did not identify risk relapse triggers. In respect of Louise Henry I heard evidence that the risk relapse triggers were well known and had been identified prior to her discharge from mental health services. I also heard evidence that prior to her death Louise Henry had contacted the police indicating that neighbours were accessing her loft [on 12.3.13, 24.3.13 and 31.3.13] and this information had been made known to mental health

	services previously supporting Louise Henry namely the CMHT [on 15.3.13] and DCC Recovery Team [18.3.13] but there was no reassessment of Louise Henry and her mental health prior to her death. A previous worker of Louise Henry's from the CMHT passed information provided to her from the police to the GP on 15.3.13 without a request being made for assessment of Louise Henry.
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. – **DCC and Derbyshire Healthcare NHS Foundation Trust.** 1. The CMHT from the evidence I heard did not understand that the DCC Recovery Team is not following the Care Programme approach, neither are lead professionals from the DCC Recovery Team acting as care co-ordinators for the purposes of the Care Programme Approach [CPA]. I heard evidence that the Psychiatrist from the CMHT understood that the social worker from the DCC Recovery Team was Louise Henry's Care coordinator for CPA purposes and was following the Care Programme Approach. I also heard evidence that when the services of the DCC Recovery Team and CMHT ceased to be an Integrated service the understanding of the psychiatrist had been that the DCC Recovery Team workers would be following the CPA. I heard evidence from DCC Recovery Team that this was not the case and that they were not following the CPA or acting as the care co-ordinator for the purposes of CPA but instead worked to the Self Directed Support framework. It is important that the CMHT understand the roles and responsibilities of the Lead professional from the DCC Recovery Team and that they are not following the Care Programme approach or acting as the care co-ordinator. It is of concern that workers from the CMHT and DCC Recovery Team who often are involved in providing multi agency mental health services and joint working to patients misunderstand each others roles, responsibilities and processes. The care co-ordinator is a key role in the management of a patient with mental health difficulties and it is important that there is no ambiguity in respect of who is acting in this capacity. 2. That both the CMHT and the Recovery Team of DCC ensure that when discharging patients all necessary processes and procedures indicated in policies are followed by the lead professional and / or care co-ordinator and that discharge letters sent to GPs and to patients identify risk relapse triggers and indicators to ensure re-assessment if there are signs of deterioration in mental health and speedy referral back to secondary mental health services if required. My concern is that the processes and procedures indicated on discharge for Louise Henry were not followed and the confusion as to roles and responsibilities risks this re-occuring.

	3. There is a misunderstanding in respect of the Recovery Team from DCC and the Recovery Team within the CMHT and potential for confusion between professionals and service users due to there being 2 services operating under the title "Recovery Team" operated by different agencies namely DCC and the CMHT. **NHS England** 4. That GPs do not appreciate the use that can be made of the Special Patient Note facility and Right Care plan facility on the EMIS system operated by GPs. I heard evidence that key information relating to patients and in particular mental health patients can be updated on to the Special Patient Note facility and the Right Care Plan facility by GPs and used to record risk relapse triggers and indicators for patient's with mental health difficulties and risk of suicide/ self harm. This enables Out of Hours Services such as those operated by Derbyshire HealthCare United to access key risk information when they are called out of hours when the GP and the full GP records with this key information is not available. There appears to be action that can be taken by NHS England through the Clinical Commissioning Groups to educate GPs as to this facility.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe: Derbyshire County Council; Derbyshire Healthcare NHS Foundation Trust; NHS England 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 13th March 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, the family care of [redacted], DCC, Derbyshire Healthcare NHS Foundation Trust, Derbyshire Health United, [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	**[DATE]** 16.1.15	**[SIGNED BY CORONER]** Séamus Cathright