IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquests Touching the Death of Vanessa Christine DADSWELL
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • Mental Health Commissioners, West Sussex County Council. • Colm Donaghy– Chief Executive, Sussex Partnership NHS Foundation Trust.
1	**CORONER** Simon Wickens HM Area Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	**INVESTIGATION and INQUEST** The inquest into the death of **Vanessa Christine Dadswell** was opened on the 13th April 2015 and was resumed on the 8th February 2016. The cause of death was found to be: 1a – Multiple injuries. A short form conclusion of 'suicide' was returned.
4	**CIRCUMSTANCES OF THE DEATH** On the afternoon of the 2nd April 2015, Mrs Vanessa Dadswell attended Whitley Railway Station whereupon she placed herself in the path of an oncoming train and died of injuries sustained. She had been referred by her GP via the urgent referral scheme to the Mental Health Services on the 30th March 2015. Her GP requested a 24 hours referral. The options made available were a 4 hour or within 5 day referral. The GP indicated a 4 hour referral was not necessary but she should be seen ideally with 24 hours. Mrs Dadswell had not been seen by Mental Health Services before her death on the 2nd April 2015. However a direct causal link between the missed opportunity of an assessment and her death could not be

	established upon the evidence.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed that any urgent referral by a GP would be categorised by West Sussex Community Mental Health as either as a '4 hour' referral or a 'within 5 day' referral. A '4 hour' referral would involve the service user having to attend A&E urgently for an assessment within 4 hours. A 'within 5 day referral' was exactly as described, an appointment within 5 days. The issue arose where a referring GP did not consider it necessary nor appropriate for a 4 hour referral and yet believed a 24 hour visit was necessary as 5 days would be too long. The deceased was not seen within 24 hours and committed suicide 3 days after the referral with no direct contact having been made. Evidence given by the Service manager for the Trust agreed that an intermediate option for referral would not be unreasonable. The **MATTER OF CONCERN** is: Consideration should be given to an alternative, intermediate referral time between the current '4 hour' and 'within 5 day' periods for referrals together with effective management thereof.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to the following: 1. Interested Persons - a [redacted] b [redacted]

	c [redacted] d Sussex Partnership NHS Foundation Trust 2. The Chief Coroner
	Signed: *Simon Wickens* **DATED this 17th February 2016**