Ms N J Mundy
Senior Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Medical Director Of Rotherham Nhs Foundation Trust** [redacted] The Rotherham NHS Foundation Trust, Moorgate Road, Oakwood Rotherham S60 2UD
1	**CORONER** I am Ms N J Mundy, Senior Coroner for South Yorkshire (East District)
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On Monday 25th July 2016 I commenced an investigation into the death of John Atkinson, 60. The investigation concluded at the end of the inquest on Tuesday 29 November 2016. The conclusion of the inquest was Suicide by Hanging.
4	**CIRCUMSTANCES OF THE DEATH** Mr Atkinson contacted the Mental health Team in July 2014 in crisis. Thereafter he received regular input from the psychiatric services until the time of his death. Input was provided by the Home Treatment Team, the Community Intensive Therapies Team and a brief period as an in-patient. A thread running throughout the treatment was a lack of effective communication between staff members and indeed with the family in terms of progression of Mr Atkinson's illness which had been diagnosed as depression and anxiety with psychotic symptoms. Furthermore, there were key events of significant self harm attempts which were not escalated by the care co-ordinator finally. Finally when the care co-ordinator left, there were no measure in place to provide Mr Atkinson with an alternative care co-ordinator or indeed to even inform him or his family that the care co-ordinator was no longer with the Trust. At the time of Mr Atkinson's final assessment by the psychiatrist six days before he passed away, a discussion with the family was lacking in detail and information and furthermore though the view taken was that there was an indication to involve the Home Treatment Team, due to a change in emphasis and seemingly an increasingly high threshold, accessing the Home Treatment Team had become extremely challenging and thus the referral was not made.
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) Lack of updated Risk Assessments when key events occurred or there was a significant deterioration in presentation. (2) Failure of the care co-ordinator to identify changes in presentation and level of risk and to seek a doctors input.

	(3) Absence of an effective and robust system to identify and then manage patients under the care of departing staff (for example care co-ordinator). (4) Lack of effective communication between mental health professionals at differing levels and also between those professionals and the patient and the patient's family. (5) Difficulty in consultant psychiatrists accessing Home Treatment Team Services when they indicate a need (since a change in emphasis in interpreting the guidelines from the end of 2014).
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you The Medical Director of Rotherham NHS Foundation Trust 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 **Monday 23 January 2017**. 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] Chief Executive, Rotherham Doncaster and South Humber NHS Foundation Trust. 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	Dated 29 November 2016 Signature_____ Senior Coroner for South Yorkshire (East District)

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