	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Trust Solicitor** **Legal Department** **Royal Devon & Exeter NHS Foundation Trust** **Royal Devon & Exeter Hospital (Heavitree)** **Gladstone Road** **Exeter EX1 2ED** **Melanie Walker** **The Chief Executive** **Devon Partnership NHS Trust** **Wonford House** **Dryden Road** **Exeter** **Devon EX2 5AF** **Chief Executive** **NHS Northern, Eastern and Western Devon Clinical Commissioning Group** **Newcourt House** **Newcourt Drive** **Old Rydon Lane** **Exeter EX2 7JQ**
1	**CORONER** I am Lydia Charlotte Brown, Assistant Coroner for Exeter and Greater Devon
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 21/03/2016 I commenced an investigation into the death of Wendy Louise Telfer, 44 . The investigation concluded at the end of the inquest on 12 January 2017. The conclusion of the inquest was accidental death. The medical cause of death was recorded as 1a Liver Failure 1b Overdose of Paracetamol 2 Asthma

4	**CIRCUMSTANCES OF THE DEATH** Wendy died on 20 March 2016 in the Royal Devon and Exeter Hospital from an overdose of purchased non-prescribed medication she had taken 5 days earlier. On the balance of probabilities, had she received appropriate care during her in patient stay between 11 – 15 March, this opportunity to self-harm would have been avoided. Opportunities were missed to keep Wendy safe.
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) It was recognised at inquest that there is a frequent need for patients with significant mental health needs to increasingly be cared for in a physical care environment, due to concurrent physical and mental health needs, and due to an increasing difficulty in sourcing psychiatric beds, which often requires a wait on a general ward. It was also acknowledged that the training of the physical healthcare staff "needs to improve", although it must be said that efforts have been made and are continuing to address this issue. From the evidence there was clear confusion regarding the application of the Mental Health Act in the physical care environment, which led in this case to Wendy being allowed to leave the ward unaccompanied and without transport, which could have been avoided with better understanding of the available restrictive legislation. (2) Wendy was to be admitted to a psychiatric bed at one stage of this final hospital stay, but she could not be transferred immediately due to the lack of beds. The Devon Partnership Trust was candid and open regarding their considerable difficulties in this regard, that have been worsening over a number of years. Currently the Court was advised that a block booking of beds has been secured in the North Somerset region, but this short term solution is financially unsustainable, and not a good solution in term of patient need and geographical location. It is accepted that the problem of psychiatric in-patient beds is a national one, but on this occasion, had a bed been available when needed for Wendy, her death is likely to have been avoided. The Court was advised that much of the difficulty is delayed discharge of patients, and it is acknowledged that this is a wider issue of social and community care and resources. This report is therefore being copied to the commissioners as well for their further consideration of the current untenable situation.

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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 11 April 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] CQC 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 14 February 2017 Signature_____ for Exeter and Greater Devon

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