H M Senior Coroner for Gloucestershire
Ms Katy Skerrett

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • **[redacted], Clinical Chair, and [redacted] Lead Commissioner (Mental Health) Gloucestershire Clinical Commissioning Group, Unit 5220, Valiant Court, Delta Way, Brockworth, Gloucester GL3 2FE and** • **[redacted] Chair and Clinical Lead, and [redacted] Acting Chief Nursing Officer, Herefordshire Clinical Commissioning Group, St Owens Chambers, 22 St Owen Street, Hereford HR1 2PL**
1	**CORONER** I am Katy Skerrett, Senior Coroner for Gloucestershire.
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 the 24th April2017 I commenced an investigation into the death of Barbara Caroline Ellis. The investigation concluded at the end of the inquest on the 25th January 2018. The conclusion of the inquest was suicide. The medical cause of death was 1A multiple injuries 1B
4	**CIRCUMSTANCES OF THE DEATH** This 52 year old lady had a significant history of physical and mental health difficulties. Following the death of her husband in 2012 she had really struggled with her loss. From 2014 she began accessing mental health services. Despite receiving support her mental state remained very fragile and she made multiple attempts to take her life. In 2017 she had been reviewed by her Psychiatrist and her GP. April was the anniversary of her husband's death and her care package was increased to reflect this. On the 4th April she saw her support worker. Mrs Ellis was making future orientated statements and gave no indication that she was planning on taking her life. She also spoke to her daughter on the telephone at approximately 5.30 pm and again no indication was given. At some point during the evening Mrs Ellis made her way to the overbridge located near to Bromsberrow Heath between junctions 2 and 3 of the M50. She tied a ligature to the bridge, and jumped off it impacting with the carriageway below and suffered multiple injuries. Mrs Ellis had left suicide notes on her person and at her home address. Her body was discovered by highway workers. She was transferred to the regional trauma centre, and investigations soon revealed the extent of her injuries. Clinicians advised that she was not fit for operative intervention, and brain stem testing was carried out. Mrs Ellis was pronounced deceased at 13.25 hours on the 6th April 2017.
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 **MATTER OF CONCERN** is as follows. – The Cross border provision of care - whether patients can access services adequately when they have a GP in one County, and pay Council tax to another. In this case Mrs Ellis had a GP in Herefordshire, but paid Council Tax to Gloucestershire. This meant that her healthcare was being provided by Herefordshire Commissioners, and her social care from Gloucestershire Social Services. This resulted in her being unable to access therapeutic services from either commission.
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 4pm 30th March 2018. 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 (1) [redacted] (2) [redacted], Acting Chief Executive of the 2gether NHS Foundation Trust, Rikenel Headquarters, Montpellier, Gloucester, GL1 1LY 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.
	Dated 2nd February 2018 Signature_____ Ms K Skerrett Senior Coroner for Gloucestershire