REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Melanie Walker** **Chief Executive Devon Partnership NHS Trust** **Wonford House** **Drydon Road** **Exeter EX2 5AF**
1	**CORONER** I am Mrs Lydia Brown, Assistant Coroner for the Exeter and Greater Devon 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.
3	**INVESTIGATION and INQUEST** On 21st February 2017 I commenced an investigation into the death of David John Ireland. The investigation concluded at the end of the inquest on 6th February 2018. The conclusion of the inquest was Multiple Traumatic Injuries Conclusion – Accidental Death
4	**CIRCUMSTANCES OF THE DEATH** David experienced an episode of acute onset psychosis and exhibited bizarre behaviour. He forced entry into a house on St James Road, Exeter and when detained in a first-floor bedroom by the residents, climbed out of the window and fell to the ground sustaining serious injuries. He died in Royal Devon and Exeter Hospital shortly after admission on 13 February 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 **MATTERS OF CONCERN** are as follows. – (1) Contact was made by Mr Ireland's friend on the day of his death with the crisis team. Mr Ireland also spoke with them during the same telephone contact call. No advice was given that Mr Ireland could present at the emergency department should concerns continue about his mental health crisis. Had such advice been given it may have impacted on the course of events and facilitated an urgent mental health assessment. This opportunity was lost as Mr Ireland was not able to make any such decision and his friend was unaware that this was an option available with sudden onset mental health symptoms.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 26th April 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: [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** 27 February 2018	**Signed** ..... **Lydia C. Brown** **H. M. Assistant Coroner for Exeter and Greater Devon** **Room 226** **County Hall** **Topsham Road** **EXETER** **Devon EX2 4QD**