REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Sarah Dugan, Chief Executive, Worcester Health & Care Trust**
1	**CORONER** I am Andrew Cox, Assistant Coroner for the coroner area of Worcestershire
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 20/9/17, I commenced an investigation into the death of Gail Ann Bannister then aged 60. The investigation concluded at the end of the inquest on 8 February 2018. The conclusion of the inquest was suicide, the medical cause of death being 1a) hanging.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Bannister had a long history of a fluctuating mental health condition. In March 2017, she was noted to suffer a deterioration following the illness and subsequent death of her father. She was seen by her GP and then referred to CARS and onto the HTT service. She was referred back to CARS in early August 2017. A Care Co-ordinator had been appointed on 20 July to facilitate psycho-social services that it was felt Mrs Bannister required and to provide continuity in her care. Her care co-ordinator did not see her between the date of her appointment and Mrs Bannister's death two months later.
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) The rationale behind discharging Mrs Bannister from the HTT to CARS was that she had been seeing too many different people. It was felt that by concentrating her care in the hands of the community consultant psychiatrist and a Care Co-ordinator, who would arrange the psycho-social services she would benefit from, this would improve her treatment. The fact that the care co-ordinator did not see her frustrated and undermined this approach. (2) During the inquest I was told that the deceased's husband tried to speak to members of the care team who were based at the Studdart Kennedy centre when a crisis developed. It took him several hours to get through. I was told there is only one phone line and that this is a known and recurring problem.

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 6 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], husband of the deceased 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	**Signed** **----------A J COX----------** **A J Cox** **9 February 2018** **HM Assistant Coroner**