REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted] **Chief Officer (Accountable Officer)** **NHS Kernow Clinical Commissioning Group**
1	**CORONER** My name is Guy Davies. I am Her Majesty's Assistant Coroner, for the coroner area of Cornwall & the Isles of Scilly
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 18th July 2017 I commenced an investigation into the death of Miriam Roach (DOB 28/03/1962 Aged 55). The investigation concluded at the end of the inquest on 29th March 2018. The legal conclusion of the inquest was Suicide. The four questions - who, when, where and how – were answered as follows. Miriam Roach died on 1st July 2017 [redacted] by hanging from a door using a ligature made from a scarf. The medical cause of death was established on the evidence as hanging.
4	**CIRCUMSTANCES OF THE DEATH** Miriam Roach had a previous medical history of depression, anxiety and alcohol dependency. The history indicated that intoxication on occasion led to self-harm. Miriam had attended a number of detoxification programmes – in 2006, 2014, 2017. Miriam had previously taken overdoses in July & August 2006, July 2008, and lastly 29th June 2017. Miriam had received support from drug and alcohol support service Addaction in relation to alcohol addiction, on and off since 2013. The death of her mother and father at the end 2016 appears to have triggered an increase in alcohol consumption. Miriam attempted suicide on the 29th June 2017 and was admitted overnight at Royal Cornwall Hospital (RCHT). On the same day Miriam informed medical staff that she was disappointed she had not died and was found to have suicidal intentions. The following day 30th June 2017, Miriam was assessed by the psychiatric team. The assessment recorded a moderate risk of self-harm when intoxicated. Miriam informed the team that she now regretted the overdose from the previous evening and indicated no plans to act on suicidal thoughts. Protective factors were identified. Miriam was found to have capacity and no grounds were identified for consideration of detention under the Mental Health Act. Miriam was then discharged from RCHT on 30th June 2017 with a care plan which did

	not include a contact plan. There was no arrangement for Miriam to be contacted by support services or any health services following discharge. The NICE guidance entitled *'Transition between inpatient mental health settings and community or care home settings'* states patients discharged from specialist mental health services should be contacted within a week, and those thought to be at risk of suicide within 48 hours. The court heard that the NICE guidance did not apply in Miriam's case because RCHT was not a mental health setting.
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) Regarding the aftercare or transition arrangements for those discharged from hospital to home with a moderate to high risk of self-harm and/or suicide following incidents of self-harm or suicide. (2) Specifically the obligations for putting in place contact arrangements for such patients.
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, namely a review of the aftercare or transition arrangements for those discharged from hospital to home with a moderate to high risk of self-harm and/or suicide following incidents of self-harm or suicide, including a review of the obligations for putting in place contact plans for such patients.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 1st June 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], Miriam's daughter. I have also sent it to [redacted], Drug Related Death Prevention Co-ordinator for Cornwall Drug and Alcohol Action Team, who may find it useful or of interest. 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	**6th April 2018** **Guy Davies**