Tony Williams
Senior Coroner for Somerset

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Peter Lewis, Chief Executive, Somerset Partnership, NHS Foundation Trust, 2nd Floor, Mallard Court, Express Park, Bristol Road, Bridgwater, Somerset TA6 4RN Rt Hon Jeremy Hunt MP, Secretary of State for Health, Department of Health, Richmond House, 79 Whitehall, London SW1A 2NS
1	**CORONER** I am Tony Williams, Senior Coroner for Somerset
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 03/07/2015 I commenced an investigation into the death of Robin Damien Richards, aged 33 years old . The investigation concluded at the end of the inquest on 09 March 2018. The conclusion of the inquest was Robin deliberately chose to suspend himself by a belt and on balance, at that time, he intended that the outcome be fatal. The Jury concluded that issues contributing to Robin's death included: communication, training, information sharing, discharge planning, care planning and risk assessment. At about 19.50 on 29th June 2015 Robin Richards was found suspended by his belt on the staircase at Highbridge Court, Burnham on Sea. He was unconscious. Emergency care was administered and he was taken to Weston General Hospital where he died at 09.20 on 3rd July 2015.Cause of death was recorded as severe hypoxic brain injury secondary to hanging.
4	**CIRCUMSTANCES OF THE DEATH** Mr Richards has a long history of contact with mental health services. He was first assessed aged 16 years. Mr Richards had diagnoses of Asperger's Syndrome, Attention Deficit Hyperactivity Disorder (ADHD) and a learning disability. In addition he had fluctuating depressive, anxious and psychotic symptoms. Mr Richards had three admissions under S2 of the Mental Health Act into hospital in quick succession. The first admission was 12/04/14 to 12/05/14 and the second was from 28/08/14 to 29/09/14. Both admissions resulted from mental and behavioural disorders due to the use of legal highs. Following each admission Mr Richards returned to supported accommodation. On 17th February 2015 Mr Richards was admitted for the third time under s2. Mr Richards was noted to be vulnerable to exploitation, had exhibited aggressive behaviour when under the influence of legal highs and expressed suicidal thoughts. As in the two previous admissions Mr Richards improved such that the 28 day detention under S2 was allowed to lapse and Mr Richards was effectively free to leave the psychiatric ward. Mr Richards had nowhere to go as a result of his former accommodation no longer being available. Mr Richards had received a number of warnings from the landlords of his supported accommodation and it was felt the accommodation no longer met his needs and his placement was not sustainable due to his previous behaviour. Mr Richards had no choice but to remain on the psychiatric ward whilst an alternative placement was found for him. Mr Richards was extremely distressed at being on the psychiatric ward with no clear idea of when and where he might move. The delay in finding a placement was a source of frustration to medical professionals. On 15th June 2015 Mr Richards transferred from the psychiatric ward to Highbridge Court,

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	Berrow Road, Burnham On Sea, Somerset. There was no formal handover. Although a discharge plan was in place it highlighted risks to others rather than to Mr Richards himself. The evidence was that there was insufficient detail in the plan about the support Mr Richards would be offered at Highbridge court. Mr Richards exhibited behaviour showing signs of distress and anxiety, he stepped out in front of cars on two occasions, superficially cut his head with a knife and tried to access bleach in a locked cupboard. The staff at Highbridge court exercised a somewhat haphazard observation policy. Follow up from the Mental Health Team was limited and the Crisis Resolution Home Treatment Team had to be called to Highbridge Court and they assessed Mr Richards reporting he did not want to return to hospital and that he should be visited daily for the next five days. This did not happen and there was only telephone contact with staff rather than face to face meetings with Mr Richards. On 29th June 2015 Mr Richards was found hanging and he subsequently died on 3rd July 2015.
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) That there exists a shortage of suitable supported accommodation for those diagnosed with Asperger's Syndrome, both in Somerset and nationally. In the case of Mr Richards this shortage resulted in him being obliged to remain on a psychiatric ward after his discharge under the Mental Health Act. This was not in Mr Richards best interests. (2) The suitability of Highbridge Court as a placement for Mr Richards which whilst CQC registered had not been CQC inspected. (3) A number of shortcomings on the part of Somerset Partnership NHS Foundation Trust ('the Trust') in Mr Richards mental health care were identified; a) Poor communication with family and between Trust staff. b) A lack of clarity in Mr Richards discharge plan and as to what Mr Richards could expect from his placement. c) An inadequate handover. d) Poor communication between Trust staff and Placement Staff and a failure to communicate with Mr Richards personally at a time of crisis for him. e) An inadequacy in the Trust's Risk Assessment process and subsequent management of risk to include only having telephone contact with staff and not speaking directly with Mr Richards

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 20 July 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] [redacted](Mother) 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 25 May 2018 Signature_____ Senior Coroner for Somerset

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