	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: NHS England South Region, South West, Devon Local Medical Committee and Livewell Southwest.**
1	**CORONER** I am Andrew James Cox, Assistant Coroner for Plymouth Torbay and South Devon.
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 23 August 2016 I commenced an investigation into the death of Graeme Robert Mathieson, then aged 46. The Investigation concluded at the end of the Inquest on 18 May 2018. The conclusion of the Inquest was Suicide – there were a number of gross failures to provide basic medical attention to Mr Mathieson who was in a dependent position. These caused or contributed to the outcome. The medical cause of death was given as 1a) Intentional Overdose of Prescribed Medication 1b) 1c) II)
4	**CIRCUMSTANCES OF THE DEATH** The background to this case together with my findings on both law and fact are set out in the enclosed copy judgement. My findings from page 20 onwards may be of most relevance to you.
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. – For NHS England South region, south-west (1) At page 20 of my judgement I found that at the appointment on 10 August 2016 the time constraints under which [redacted] was obliged to work meant that he was faced with trying to achieve the impossible. I said that I was sure that the very real constraints of time had had a direct impact on the outcome of the appointment. I said that it would have been better if the likely difficulties in this regard had been recognised at the point that Mr Matheson or his sister had asked to have an appointment. If there had been some sort of triage system in place, as I understand to be the case in other practices, this could have been recognised from the outset. I am aware that while some GP practices operate triage system there are plenty of others that do not. I think it may be beneficial for the facts of this case to be shared with all GPs in the area as a learning exercise. What I want to ensure, as far as possible, is that another GP is not placed in the same situation as [redacted] on 10 August 2016 with the nearly inevitable conclusion that a patient's serious psychiatric condition is not recognised.

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	For Devon Local Medical Committee (2) I repeat the concerns set out at (1) above. I want to ensure that the lessons to be learned from this inquest are shared with all local practices in the hope that similar future fatalities may be avoided. (3) It became apparent during the course of the inquest that a number of professionals (both GPs and care coordinators) were confused or unclear about the correct pathway for [redacted] to follow once he had been wrongly discharged from the local CM HT. I indicated that I felt it may be sensible for Livewell Southwest to add a 'Professionals' tab or page to its website so that doctors and other professionals could refer to it in the event of uncertainty. I suggested that it may be sensible for a doctor representing GPs locally to sit down with an individual from Livewell Southwest to ensure that any areas of ongoing confusion were recognised and appropriately addressed. For Livewell Southwest (4) To consider the development of a 'Professionals' tab or webpage setting out current pathways for mental health patients to follow in specific circumstances as outlined at (3) above. To liaise with a GP representative to identify areas of current confusion and to assist in the creation of a clear and comprehensible summary document. (5) To consider whether, in certain circumstances, it may be appropriate to authorise care coordinators or other professionals to exercise clinical judgement and depart from stated operational policy. To assess the circumstances in which such a decision may be appropriate and the process to be followed. To consider the drafting of an express provision to this effect within the operational policy and the need for specific training for the clinicians concerned. (6) To consider whether there is a need to make the current transfer process more robust. To review recent transfers (over a specific timeframe) to identify whether there is an issue over failed transfers. If so, to consider what further steps may be necessary to strengthen the process.

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 15 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] Livewell Southwest, NHS England South Region, South West, [redacted] and [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	Dated 18/5/2018 Signature_____ for Plymouth Torbay and South Devon

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