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.** Mr Ron Shields, Chief Executive of Dorset Healthcare University NHS Foundation Trust, 4-6 Sentinel House, Nuffield Industrial Estate, Poole BH17 0RB
1	**CORONER** I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset.
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 the 4th October 2017, an investigation was commenced into the death of Joanne Elizabeth Richardson, born on the 3rd February 1962. The investigation concluded at the end of the Inquest on the 25th April 2018. The Medical Cause of Death was: 1a Hanging The conclusion of the Inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** On the 26th September 2017 the deceased, who was known to suffer with mixed anxiety and depressive disorder, was found suspended by a ligature which was attached around the leg of a bed and passed through the bannister of the staircase at her home address at [redacted]
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. During the inquest evidence was heard that:

   i. Mrs Richardson was under the care of the Dorset Healthcare University Foundation Trust (DHUFT) in relation to her mental health. Her latest period of treatment began in June 2017. She was under the care of the Community Mental Health Team (CMHT) from that time until the time of her death on the 26th September 2017. The CMHT had referred her to the West Dorset Steps to Wellbeing Service for therapy.

   ii. She was assessed by the Psychiatrist from the CMHT on the 13th July 2017, 8th August 2017 and 23rd August 2017. The Psychiatrist left the Trust and her case was then managed by a Nurse Prescriber who assessed her on the 19th September 2017. During these assessments, her risk of harm was deemed to be low.

   iii. She was reviewed by the Steps to Wellbeing Service on the 21st August 2017 when she was in low mood and had thoughts, but no plans, of ending her life. The team felt that her risk was too high for treatment by the Service and they therefore intended to refer her back to CMHT. Mrs Richardson was only advised of this in writing in a letter dated the 21st September.

   iv. The details of that assessment were never referred to the CMHT. They were therefore not aware of how she presented or the risk assessment made by the Steps to Wellbeing Service. This information could have been very valuable to those in the CMHT who assessed her on the 23rd August and 19th September.

   v. Evidence was given that some of the Steps to Wellbeing Service have access to DHUFT records, namely RIO records, but not all of them do. Evidence was further given that they do not write entries in these records. Those carrying out assessments therefore are not likely to have access to all information available to DHUFT in relation to the patient.

   vi. Further on the 28th August 2017, Mrs Richardson contacted the Crisis Team within DHUFT stating that she had suicidal thoughts of ending her life by hanging. A call was made from the Crisis Team to the CMHT and a Community Psychiatric Nurse was spoken to. There was however no follow up after this, or any written communication with anyone involved in her care.

   vii. Valuable information therefore, in relation to a patient, is not being communicated to those involved in the care. There does not appear to be joined up working between the different teams within the Trust. This could therefore lead to inaccurate risk assessments and a future death.

	2. I have concerns with regard to the following: i. That there is a lack of communication between the different teams in DHUFT in respect of a patient's care and as a result there could be the death of a person in the future. ii. I would therefore request that there is a review of the policies by DHUFT in relation to the communication between the different teams within DHUFT, particularly between the CMHT and the Steps to Wellbeing Service.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and/or 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, 3rd 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: (1) [redacted] Mrs Richardson's husband 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** **8th May 2018**
	Signed **Rachael C Griffin**