C.G.BUTLER
SENIOR CORONER · BUCKINGHAMSHIRE

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Oxford Health NHS Foundation Trust**
1	**CORONER** I am CRISPIN GILES BUTLER, Senior Coroner, for the coroner area of Buckinghamshire
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/pdfs/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 18th September 2017 I commenced an investigation into the death of Lewis Daryl COLGAN. The investigation concluded at the end of the inquest on 30th April 2018. The findings included that it was possible, but not probable, that the following omissions in Lewis' mental health care contributed to his death: (1) the frequency of care programme meetings did not meet local or national standards; (2) psychology engagement stopped in July 2016 with no explanation; (3) there was no supervision of the last care coordinator with conduct of Lewis' case; (4) there was no coordination of mental and physical health care; (5) there was little evidence of effective communication between the mental health team and Lewis in relation to his care; (6) at the time of his death Lewis was unaware of a place on an anxiety management course which was causing him concern prior to his death. The medical cause of death was recorded as 1a. Multiple Severe Traumatic Injuries caused by 1b Collision with Train The conclusion of the inquest was suicide
4	**CIRCUMSTANCES OF THE DEATH** At approximately 1608hrs on 15th September 2017 Lewis Colgan was captured on CCTV at Princes Risborough Station jumping from the platform onto the track into the path of a northbound non-stop passenger train. He was struck by the train and died immediately at the scene as a result of the unsurvivable injuries he sustained. It was not possible for those who engaged with Lewis on the date of his death to have predicted the event which took place subsequently that day.

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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 could 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) It was clear from the evidence that the role of the care coordinator is very important in terms of engagement with patients, conducting risk assessments, coordinating necessary or periodic meetings and providing regular input to the care team. In Lewis' case the evidence indicated that the last care coordinator with conduct of his case had not received supervision, that the caseload was, for a period, incompatible with part time working, and that the frequency of engagement with Lewis had reduced compared with what had occurred in previous years. There were also concerns about upward supervision of the care team during this period. Whilst evidence was given that the supervision arrangements are being addressed, there remain concerns that supervision within teams and cross-supervision between teams, particularly of the critical role and caseload of care coordinator, may still lack robustness. (2) Lewis' mental health care revealed issues with regard to management of staff changes and sickness and particularly coordination of continuity of engagement and care in the context of Lewis' care plan in the absence of key participants in his care on long term sick leave, notably the roles of care coordinator and psychologist and, notwithstanding evidence indicating steps being taken to address staffing issues, there remains a concern that, given the personal nature of the mental health care provided to individuals and the significance of regular engagement with specific individuals, that provision of care in compliance with specified care plans may be compromised. (3) There did not appear to be a robust reactive process for alerting members of the care team in relation to overdue Care Programme Approach (CPA) meetings nor a proactive approach to addressing the scheduling of these. Evidence given during the Inquest from different Trust witnesses appeared to identify a difference of opinion as regards what the policy was for frequency of CPA meetings. A concern exists regarding knowledge of what the current policy is and how it is being applied. (4) Whilst a Root Cause Analysis had been undertaken and a report provided, there were concerns raised during the Inquest with regard to staff training, which the report did not address, and the last care coordinator with conduct of Lewis' case was not able to participate in the investigation, nor the Inquest. The report did not include an ongoing action to engage with that care coordinator in order to fully address the issues raised in that investigation. As a result, there remains an ongoing concern about the robustness of the investigation and actions identified.

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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 4th 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 family of Lewis Colgan. 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	**Date:** 9th MAY 2018 **Signed:** C Crispin Butler **Crispin Giles Butler, Senior Coroner for Buckinghamshire**

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