	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Dr A Morris, Chief Executive Officer, Livewell South-west, Windsor House, Tavistock Road, Plymouth, PL6 5UF**
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 9 September 2016, I commenced an investigation into the death of Martin Glyn Baker, then aged 48. The investigation concluded at the end of the inquest on 19 April 2018. The conclusion of the inquest was prescription drug-related death. It is likely Mr Baker suffered from a slow metabolism which caused potentially toxic levels of venlafaxine, prescribed to him, to build up. Together with a deteriorating physical condition and mild myocardial scarring found at post-mortem, it is likely this induced a fatal cardiac arrhythmia. The medical cause of death was given as 1a) drug toxicity
4	**CIRCUMSTANCES OF THE DEATH** Mr Baker suffered with mental health issues for over 20 years. He had previously attempted suicide on a number of occasions. After a failed attempt to take his own life following a jump from height he fractured his spine and was left confined to a wheelchair. Psychiatric support for Mr Baker was provided through Livewell South-west and I heard at inquest from [redacted] and [redacted] both of whom saw the deceased. Prior to the deterioration in Mr Baker's condition that led to his demise, [redacted] had decided to stop a prescription of lithium. This was as a consequence of excessive thirst complained about by Mr Baker which, in turn, led to the consumption of a large number of fizzy drinks and resulted in problems with urinary incontinence. [redacted] was unaware, at the time of his decision, that there had been earlier failed attempts to stop the lithium prescribed to Mr Baker. [redacted] was also unaware that Mr Baker had signed a form of consent authorising Livewell South-west to discuss care arrangements made for him with his family.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) It was accepted in evidence that there had been a lack of communication with the family. They had not been involved in any psychiatric reviews instead, on one occassion, a consultant was left to rely upon information provided by a junior healthcare assistant. At inquest I expressed my view that where a patient has signed a consent form authorising discussion of relevant

	events with the family, the default position should be that there will be involvement of the family in the absence of any good reason not to do so, for example, a patient's subsequent express instruction not to share something with the family. In this case the family were unaware that Mr Baker had been discharged from psychiatric support and were unaware of what to do in the event of deterioration in Mr Baker's condition. (2) It was also accepted in evidence that at the time of these events there was a shortage of care coordinators something described as "very far from ideal." I was advised that this situation has now been corrected. Nevertheless, it was the clear view of the family, which I accepted, that in the absence both of a care coordinator and the involvement of the family there had been no one to act as an advocate on Mr Baker's behalf, something that had been to his detriment. (3) It was accepted in evidence by [redacted] that his risk assessment failed to address periodic impulsivity that Mr Baker demonstrated. I found this was not causative of the death. Nevertheless, I felt this was a point of learning that may well have a bearing in the care of future patients and I felt it appropriate to bring it to your attention.
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 1 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] 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 3/5/ 2018 Signature_____ for Plymouth Torbay and South Devon