REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

Benjamin Colin Williamson

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. CMHT Commissioners** **2. Addaction** **3. Chief Coroner**
1	**CORONER** I am Andrew Cox, Assistant Coroner for the coroner area of Cornwall and Isles of Scilly.
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** An Investigation was opened into the death of Mr Benjamin Williamson on 11 April 2018 following his death on 4 April. This culminated in an inquest on 8 November 2018 where I found Mr Williamson had died from 1a) Asphyxia 1b) Hanging II) Alcohol intoxication I recorded a Conclusion of Suicide.
4	**CIRCUMSTANCES OF THE DEATH** Mr Williamson had a long history of alcohol-related issues for which he had been receiving treatment from Addaction and Freshfield. He had regular contact with his GP and had appeared to be doing well. His death was a shock to all concerned.
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. – CMHT Commissioners At inquest, I heard from [redacted], a partner at Mullion and Constantine Group Practice and the Locality Lead for Commissioning. Mr Williamson was his patient. [redacted] told me that Mr Williamson had been referred twice to CMHT. On both occasions, he had been seen, assessed and discharged. [redacted] described this as having a significant impact upon his patient who was left feeling he was not ill enough to be worthy of support. [redacted] expressed his view that the system is not set up to serve the population. He said it was his experience that patients like Benjamin are bounced between the various mental health services seemingly with no one willing or able to accept responsibility for providing professional care. [redacted] said he anticipated CMHT had met the letter of its contractual

	commitments but he felt it had failed to meet the needs of his patient. [redacted] identified that the problem was particularly acute for patients who have a mental health issue plus an alcohol (or drug) problem. He felt that while referring Benjamin to Addaction had addressed his alcohol-related concerns, there had been a total lack of consideration of any underlying mental health issue. This is not the first occasion on which observations of this nature have been made before me although in [redacted] I have rarely had a more articulate or well-placed witness. Addaction [redacted] told me that after referring Benjamin to Addaction he had no communications or feedback from the service. I heard from [redacted] in this regard. It was accepted that there should have been more liaison with the GP and that, in particular, a letter from the doctor in January 2018 was not answered and should have been. Upon further exploration, it emerged that Benjamin had not given full consent for disclosure to his GP. I was told that his Recovery Plan had been reviewed on 25/5/17, 16/8/17, 27/10/17 and 12/2/18. I was advised that the issue of consent should have been considered at these reviews but that did not appear to have happened. Both Benjamin's mother and [redacted] were of the view that if this matter had been dealt with fully, consent for disclosure to the GP would have been provided. [redacted] felt that the lack of feedback compromised his ability to provide care to his patient.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. CMHT Commissioners Please consider whether the system is sufficiently 'joined up' to meet adequately the needs of patients like Benjamin. If there are gaps please bring these to my attention so I may direct this concern to central government should that be appropriate. If you have had correspondence or other discussions with government on the point please bring this to my attention and provide disclosure on a confidential basis to me only. Please ensure that contact is made with [redacted] so that his experiences and insights may properly be taken into account. Addaction Please review the processes/procedures in place for dealing with consent and the sharing of information with primary care practitioners. Please involve [redacted] in your review to ensure any lessons from this incident are identified and learned.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 12 February 2019. 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. I have also sent it to [redacted] and [redacted] (Drug Related Death Prevention Co-ordinator), who

	may find it useful or of interest. 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	**12/12/18**	**Mr Andrew Cox**