ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, Hampshire County Council** **2. The Chief Executive, Southern Health NHS Trust**
1	**CORONER** I am David Clark Horsley, senior Coroner for the Coroner area of Portsmouth and South East Hampshire.
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 21 November 2017 I commenced an investigation into the death of George Daniel TWIDDY age 23. The investigation concluded at the end of the inquest on 28 March 2019. The conclusion of the inquest was cause of death: 1a. Hanging. Narrative Conclusion: George Daniel TWIDDY took his own life whilst suffering from severe and distressing psychiatric illness.
4	**CIRCUMSTANCES OF THE DEATH** At about 14:20 hours on Fifteenth November 2017 George Daniel TWIDDY was found hanging from a tree in Warren Copse, Petersfield. He was taken to Queen Alexandra Hospital, Portsmouth, where he was diagnosed to have suffered an un-treatable brain injury. He died at the hospital at 05:08 hours on Seventeenth November 2017.
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. – At George's Inquest I heard evidence that there was a lack of clarity in the days leading up to his death as to which of the two agencies that had been involved in his care (Hampshire AMHP Service and Southern Health NHS Trust's Early Intervention Psychosis Team) were in a position to provide him with immediate assistance. His parents were confused as where help would come from and practitioners from the two agencies were unclear as to where the responsibility lay. Although an improved explanatory leaflet for families about the responsibilities of the agencies is now in the course of being finalised and liaison to clarify respective roles has now taken place between senior managers of the agencies, it appears to me that a better understanding of those roles would be achieved if the practitioners actually involved in patient care themselves liaised more about what action and support should be made available to patients and relatives in crisis situations such as that faced by George and his family in the last days of his life.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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, namely by 4th June 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 following Interested Persons [redacted] George's parents. 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	**08 April 2019** **David Clark Horsley**