REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

Dr Geraint Brierley Hughes, deceased

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Dr Wilkinson, Medical Director, Cornwall Partnership Foundation Trust**
1	**CORONER** I am Andrew Cox, Acting Senior Coroner for the coroner area of Cornwall and the 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** On 3/12/13, an inquest was opened into the death of Dr Geraint Hughes who died on 15/11/13. The inquest culminated in a final hearing on 14th & 15th August 2019 with a Conclusion recorded that Dr Hughes was Unlawfully Killed. The cause of death identified at post-mortem was: 1A) Stab wound to chest.
4	**CIRCUMSTANCES OF THE DEATH** The deceased's wife had been allowed home leave from a hospital ward. She had been diagnosed with severe depression and anxiety with fluctuating psychotic symptoms. While the risk she posed to herself had been assessed, there had been no assessment of the risk she posed to others. There was no history of violence and no other warning markers. On 15/11/13, Doctor Hughes was stabbed once in the chest by his wife. He died at his home address. [redacted] subsequently pleaded guilty to a charge of manslaughter on the grounds of diminished responsibility.
5	**<u>CORONER'S CONCERNS</u>** 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) In the Trust's own Serious Incident Report and the separately conducted Domestic Homicide Review, it was noted that a formal carer's

	assessment had not been completed with Doctor Hughes. It was noted that while this could not be said to have been causative of the outcome, nevertheless, it represented a departure from best practice. I was advised that the Trust's electronic case management system (Rio) was now capable of customisation and had been adapted to ensure that a carer's assessment was mandatory in cases where domestic abuse was present. It may be that you will feel, on reflection, an audit of compliance with this requirement may be useful in assessing how robustly the Trust is performing in this regard. You may also feel it noteworthy to reflect that, in the instant case, there had been no record of domestic abuse. You may wish to consider whether it is appropriate to mandate a carer's assessment in slightly wider, clearly prescribed circumstances. 2) The reviews into the circumstances of this death had also identified a lack of regular contact by the case coordinator. In turn, this meant that care plans and risk assessments were not regularly updated. Of note, this has not been identified in the usual supervisory reviews. You may wish to reflect how the supervisory arrangements can be made more robust to prevent repetitions of this occurring in the future and, accordingly, reduce the risk of similar fatalities from happening again.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 15/10/19. 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: the family of Doctor Hughes. 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]** **[SIGNED BY CORONER]** **Mr Andrew J. Cox** **16/08/2019**