Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Chief Executive, Aneurin Bevan University Health Board
1	**CORONER** I am **Caroline Saunders,** Senior Coroner for the Area of Gwent
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 **11 /10/2018** an investigation was opened into the death of **Rory Karl Attwood DOB 28/6/96** The investigation concluded at the end of the inquest on: **3/11/2020** The conclusion of the inquest was recorded as: **Suicide** The medical cause of death was: **1a) Acute Methylenedioxyamphetamine (MDMA) Toxicity**
4	**CIRCUMSTANCES OF THE DEATH** Rory Attwood had a history of mental health problems. On 27 July 2018 Rory jumped from Union Street bridge in Newport, South Wales and injured his legs. He underwent a psychiatric assessment at which time he denied any suicidal attempt and that he had slipped when drunk. A further assessment revealed that whilst Rory had no obvious immediate suicidal intent, of concern was the fact that he showed no remorse for his actions. On 31st August Rory discharged himself from hospital. He underwent a social care assessment at which time it was confirmed that Rory needed to he re-homes but there was no further involvement in Rory's care from the adult Disability team. Furthermore Rory was not followed up by community mental health teams.

	It is obvious that Rory was vulnerable and yet there was no statutory monitoring arranged because he did not fall squarely into a box of social, physical or mental health. Rory continued to ruminate over ending his life. At about 5am on 9/10/18. Rory's father entered his son's bedroom and discovered that Rory had died. Emergency services were called but Rory could not be revived and the paramedics confirmed his death at 05:25 hours. A post mortem examination concluded that Rory had suffered an acute cardiac event and that Rory had in his blood [redacted] of MDMA normally consumed for recreational purposes. In the absence of any underlying cardiac pathology the pathologist's opinion was that the cardiac death has on balance been caused by the consumption of an excessive quantity of MDMA. Following the inquest an internal investigation was undertaken, by Aneurin Bevan University Health Board and recommendations were made in relation to more cohesive working practices between partner agencies. At the inquest Rory's General Practitioner, Dr [redacted] gave evidence. He was asked about how practices had changed since Rory's death. Dr [redacted] admitted that General Practitioners rarely (and he has never been) invited to participate in a Serious Untoward Incident Review when a community patient has died.
5	**CORONER'S CONCERNS** During the course of the inquest, 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: - The purpose of undertaking a Serious Untoward Incident Investigation, is to identify necessary organisational changes which can improve the outcomes for patients and hopefully prevent future deaths. Rory had been discharged from acute services and was under the care of his General Practitioner. In keeping with many people he had been involved with different arms of ABUHB (primary, acute and psychiatric) He had been involved with social services. After his death the charity MIND wrote to me and expressed concerns that Rory had fallen between gaps in services. This was addressed in the internal investigation undertaken by ABUHB, however it is surprising that his GP was not involved in this review and Dr [redacted] told me that GPs are rarely asked to participate in these investigations. In order that lessons can be learned and opportunities identified for better partnership working around patients, it would seem appropriate that the patient's

	primary care contact (especially when being supervised in the community) be involved in internal / serious incident reviews.
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. I should be grateful if the following information be provided to me: Confirm whether it is your intention to review the current process of serious incident investigation and ensure that General Practitioners (and indeed any other relevant third party agencies) are to be routinely involved in serious incident reviews in the future.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely **6th February, 2021,** I, the Coroner, may extend this 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 necessary
8	**COPIES AND PUBLICATION** I have sent a copy of my report to the Chief Coroner and the following Interested Person (s) • The father of Mr Rory Attwood • The mother of Mr Rory Attwood 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 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 10/12/2020** Signed  Caroline Saunders **Her Majesty's Senior Coroner for the Area of Gwent.**