	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Joint Commissioning Manager, Cornwall Council;** [redacted] **2. [redacted], Head of Joint Strategic Commissioning, KCCG** [redacted]
1	**CORONER** I am Andrew Cox, the 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 9/11/21, I concluded an inquest into the death of Emma Burbury, 45, who died on 19/9/18. . The medical cause of death was recorded as: 1a) Unascertained 1b) 1c) II) I recorded an Open Conclusion.
4	**CIRCUMSTANCES OF THE DEATH** Emma was well known to both We Are With You and the Community Mental Health Team (the Trust.) having had treatment from them since approximately 2013. Historically, there had been mixed levels of engagement. It was felt that Emma presented with symptoms attributable to previous trauma in her life. The Trust indicated that she would need to be sober before treatment could be considered. In July 2017, she was re- assessed after a period of abstinence from alcohol and it was felt appropriate to look at instituting treatment with her. Unfortunately, there was then a shortage of care coordinators within the Trust. The clinicians present had larger workloads than ideal and there were waiting lists for individuals newly referred. There was a period of approximately one year before Emma was seen again by which time she had relapsed into drinking. Emma had an in-patient detoxification but then self- discharged during rehabilitation as a consequence of increased paranoia. She became involved in a short- term relationship with an individual in Penzance and during the course of that relationship fractured both wrists when she fell or was pushed down stairs. Subsequently, she returned to her home address in East Cornwall and formed another short-term relationship. On 18/9/18, I found that she was involved in an altercation with her new partner as a consequence of which she suffered a number of seemingly minor injuries. She collapsed at the scene and was taken to hospital in Derriford but could not be resuscitated. The forensic pathologist who carried out the post-mortem examination felt it was possible the injuries she suffered in the altercation had caused or contributed to her death but the evidence was insufficient to say this was probable or certain. A murder investigation that been commenced was discontinued at this point.

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. It was accepted in evidence that it was "very regrettable" Emma was not taken on to caseload after her assessment in July 2017. There was clearly a missed opportunity to work with her while she was open to treatment. It was accepted that there was no guarantee this would have avoided the eventual outcome, but it was recognised a better service needed to be provided to those presenting with a dual diagnosis, like Emma. During the course of the inquest, I was provided with a new dual diagnosis policy that has been developed by a number of the key agencies. I was told WAWY have signed up to this and the Trust is hoping to do so as soon as current workloads have become more manageable. You may feel this is an initiative to be encouraged. I heard also that a complex needs manager [redacted] has been appointed by Cornwall Council and will be chairing monthly meetings with the two organisations to try and ensure appropriate care is provided to these challenging patients. I heard also that there were a number of steps that could be taken to facilitate the process and develop better working relationships when dealing with dual diagnosis patients. In particular: a] I heard that CMHT staff have read-only access to WAWY notes and records, but this fact is not widely known amongst Trust stuff. It was recognised that a reciprocal arrangement allowing WAWY clinicians to have read-only access to the Trust's RiO records would be of benefit. I understand a formal request in this regard has been made and is receiving due consideration. One of the most common concerns I hear at inquest is the difficulty with communication between separate organisations and this may also be an initiative you feel able to support in delivering a more integrated service. b] There was concern raised on the part of We Are With You that clients referred to the Trust were too easily discharged, for example, where they failed to attend for two appointments. It was felt a more assertive approach towards engagement would be beneficial. You may feel it would be desirable to try and minimise the amount of wasted and limited CMHT/WAWY resource through non-attendance at appointments or otherwise. You may consider reflection on how this can best be achieved through a more joined up approach would be sensible. c] It was felt patients referred to the Trust who did not fall within the strict parameters of a severe and enduring mental illness were discharged without sufficient thought being given by the Trust's clinicians to whether another agency such as Valued Lives may be able to offer assistance. You may feel it would be a worthwhile exercise to consider how to join up the wider services available within the Trust, the voluntary sector or elsewhere.
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 9/1/22. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken to develop arrangements for the future treatment of patients with a dual diagnosis, 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] (WAWY) Dr [redacted] (CMHT.) 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]** **11/11/21**