Regulation 28: Prevention of Future Deaths Report

[redacted]

THIS REPORT IS BEING SENT TO:

1. [redacted] -Chief Executive at Coventry & Warwickshire Partnership NHS Trust

1. CORONER

I am: Sean McGovern, Senior Coroner for Warwickshire, Warwick Justice Centre, Newbold Terrace, Royal Leamington Spa.

2. CORONER'S LEGAL POWERS

I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and

The Coroners (Investigations) Regulations 2013, regulations 28 and 29.

3. INVESTIGATION and INQUEST

On 13th August 2021, I commenced an investigation into the death of [redacted] (aged 42 years). The investigation concluded at the end the inquest on 28th March 2022 at Warwickshire Coroners Court.

4. CIRCUMSTANCES OF THE DEATH

[redacted] was found hanging on 25 July 2021 at his home address [redacted].

On 2nd May 2021, he presented at University Hospital Coventry & Warwickshire with suicidal ideation. He was seen by a Community Mental health Nurse on 4th May 2021. From the 5th May to 20th May 2021 he was given a crisis bed at Harry Salt House. He returned home and was seen regularly by the Crisis Team. On 19th June he was transferred to Community Mental Health Team. He was on a waiting list for a Care Co-ordinator but a Care -Ordinator was not appointed before he died. On 9th July 2021, [redacted] raised her concerns that a Care Co-ordinator had not been appointed. On 23rd July 2021, [redacted] telephoned the Mental Health Team in a very distressed state asking why the waiting list is so long and explained that he didn't have anyone in the Mental Health Team to talk to. He was explained to him that he could go to A&E or call the Samaritans if he felt unsafe.

5. CORONER'S CONCERNS

During the inquest, the evidence and information 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:

i. I am concerned that the failure to appoint a Care Co-ordinator may have contributed to [redacted] death.

ii. I am concerned that there remain significant staffing shortages in the North Warwickshire area. I heard evidence that staffing was 65% below recommended levels as of March 2022.

6. ACTION SHOULD BE TAKEN

In my opinion, action should be taken to prevent future deaths and I believe that you 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 23rd May 2022. 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 following:

1. HHJ Teague QC the Chief Coroner of England & Wales Chief Coroner's Office, 11th Floor Thomas More, Royal Courts of Justice, Strand, London, WC2A 2LL. chiefcoronersoffice@judiciary.gsi.gov.uk
2. [redacted]

I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

I may also send a copy of your response to any other person who I believe may find it useful or of interest.

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.

Date: 28th March 2022