REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, Dorset Healthcare University NHS Foundation Trust**
1	**CORONER** I am Richard T Middleton, Assistant Coroner, for the Coroner Area of Dorset
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 the 17th August 2016, an investigation was commenced into the death of Ryan Albert Frederick Merna, born on the 19th November 1986. The investigation concluded at the end of the Inquest on the 29th March 2022. The Medical Cause of Death was: 1a Stab wounds to the chest and abdomen The conclusion of the Inquest recorded that Ryan Albert Frederick Merna was unlawfully killed in circumstances where the perpetrator was under the care of mental health services and there was a missed opportunity to reassess the risk the perpetrator posed to others in light of new information disclosed 5 days before Mr Merna's death.
4	**CIRCUMSTANCES OF THE DEATH** **Mr Merna died from injuries sustained in a knife attack at his home address on 14/8/16. On the 8th August 2017 the perpetrator of the assault was convicted at Winchester Crown Court of the offence of Manslaughter on the grounds of Diminished Responsibility. The perpetrator was being treated as an outpatient under the care of the Dorset Forensic Team from May 2016 until Mr Merna's death. His treating psychiatrist saw him in person on 3 occasions on 26/5/16, 29/6/16 and 10/8/16. He was seen regularly by outpatient support in the form of a Care Coordinator and a Forensic Social Worker.**

	The Forensic Social Worker was trying to find suitable accommodation as the perpetrator was of no fixed abode. On 9/8/16 the Forensic Social Worker accompanied the perpetrator to an assessment meeting at a possible housing provider. During the course of that meeting the perpetrator disclosed that he was in possession of a knife, that he was sleeping rough and he needed the knife for his own protection. On 10/8/16 there was a Care Programme Meeting at which the Psychiatrist, Care Coordinator, Social Worker and perpetrator were all present. One of the purposes of the meeting was for the team to raise any significant developments so that a risk assessment could be made. The disclosures made at the housing assessment on 9/8/16 were neither documented at the time nor raised during the CPA meeting on 10/8/16.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: 1. During the inquest evidence was heard that: i. The members of the Dorset Forensic Team did not probe as to where the perpetrator was sleeping. ii. The disclosure made by the perpetrator that he was in possession of a knife was not probed further by the Social Worker. iii. The disclosure made by the perpetrator that he was in possession of a knife was not recorded contemporaneously in the perpetrator's records. iv. The disclosure made by the perpetrator that he was in possession of a knife was not raised during a Care Programme Meeting held the day following the disclosure.

	2. I have concerns with regard to the following: The Trust Clinical Risk Policy should make reference to the fact that i. The Trust should use its best endeavours to identify where a service user is living by reference to information to be sourced from the individual and from that which may be in the public domain. ii. Where there is disclosure that a service user is in possession of an offensive weapon this must be documented; there must be a documented discussion as to the response; the information must be passed to the police; any action taken by the Trust and/or the police to be documented.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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, 31st 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 Chief Coroner and to the following Interested Persons: (1) [redacted] (2) [redacted] 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	**Dated** 5/4/22
	Signed **Richard T Middleton**