Her Majesty's Senior Coroner for Exeter and Greater Devon
Philip Spinney

26 July 2022
Case ref: 311092

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

[redacted]
Devon Partnership NHS Trust
Wonford House
Dryden Road
Exeter
EX2 5AF

CORONER

I am Alison Longhorn Area Coroner for the coroner area of Exeter and Greater Devon

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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 14th November 2019 I commenced an investigation into the death of Archi Johnson.
The investigation concluded at the end of the inquest on 11th May 2022.
The conclusion of the inquest was suicide, the medical cause of death being hanging.

CIRCUMSTANCES OF THE DEATH

Archi was diagnosed with Schizoaffective Disorder with a history of depression, self-harm and suicidal ideation. On 5th November 2019 Archi was voluntarily admitted into Moorland View at North Devon District Hospital having told mental health professionals that he had intrusive thoughts of taking his own life and he did not feel safe to go home. During an admission on the ward two months earlier, Archi had attempted to take his own life by ligaturing [redacted]
On admission, Archi's risk level was assessed as medium and he was placed on Level 1 observations.
On 7th November 2019 Archi was found hanging [redacted]

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. –

1.Evidence was heard regarding the manner in which information crucial to the formulation of risk assessments was recorded and shared:

a)Two types of risk assessments were completed, with no system to ensure that important information is present on both;

b) The previous incident in which Archi had attempted to take his own life in very similar circumstances on the ward was not clearly entered on the risk assessments used by staff and therefore not known to a number of those responsible for his care;

c) Those responsible for his care accepted that the above incident was one of which they would have wanted to have knowledge;

d) The absence of that information may have affected the subsequent decisions made regarding the setting of risk level, observation level and removal of potentially dangerous ligature items.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe that your organisation has the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 23rd September 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to Archi's Family.

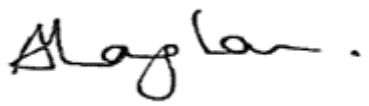
I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

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 by the Chief Coroner.
26 July 2022

Signed:



Alison Longhorn
Area Coroner
Exeter and Greater Devon