	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **[redacted], Chief Executive of Kent and Medway NHS Social Care Partnership Trust**
1	**CORONER** I am Joanne Andrews, Area Coroner, for the Coroner Area of North East Kent.
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 20 September 2020 I commenced an investigation into the death of Robert Arthur Brown, 68. The investigation concluded at the end of the inquest on 30 November 2021. The conclusion of the inquest was that Mr Brown died from 1(a) Severe Head Injury (b) Fall 2. Self-harm. The conclusion of the inquest was Suicide.
4	**CIRCUMSTANCES OF THE DEATH** Robert Arthur Brown had a history attempts to take his own life and of suicidal ideation. He was under the treatment of mental health trust during 2020. Mr Brown was assessed as being a high risk of suicide on 3 September 2020. He reluctantly agreed to an admission as a voluntary patient to

hospital. At this time, the family and Crisis Team could not keep Mr Brown safe in the community. His wife was known to be his carer and had taken responsibility for Mr Brown's medication.

Mr Brown remained in hospital for four days. On the 4th day he indicated he wished to be discharged. He indicated that he no longer had suicidal thoughts and appeared to have made plans as to the changes that he was going to make which differed from those previously. He was assessed by the clinicians for discharge, and this was agreed.

Mr Brown's wife was not contacted and advised that he would be discharged. Mrs Brown only became aware of this when Mr Brown was in transit back to his home address. The evidence from the clinicians was that Mr. Brown had capacity and did not want them to contact Mrs. Brown and that he would make her aware of his discharge. The instruction by Mr Brown not to inform Mrs Brown was not documented and the oral evidence from KMPT witnesses was that they could not inform Mrs Brown as this would be contrary to Mr Brown's wishes.

On 9 September 2020, Mr Brown was found fatally injured at the cliffs close to his home address.

A Root Cause Analysis Report ('the Report') prepared by KMPT and evidence was heard at inquest as to the findings. The Report included a finding that the ward should have contacted Mrs Brown to contribute to the discharge planning but did not do so. The Report recommended that where there had been carer breakdown then there should be discussion with that carer on admission and discharge. At inquest a witness was called to advise on the implementation of the Improvement Plan but was unable to explain to the Court the meaning of "carer breakdown" and when the actions would therefore be engaged. Subsequent documentation from KMPT provided evidence of the liaison with carers but did not address the

	identification of "carer breakdown" and how this would be addressed on a discharge where there was no CPA in place.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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. The Report states that "Carer breakdown is likely to have increased the risks of suicidality on discharge as this was not addressed during the hospital admission nor on discharge". The evidence from the KMPT witness and subsequent documentation does not address what is meant and understood to be "carer breakdown" and as such may not be identified prior to discharge. 2. As there was no process in place to require contacting a carer on discharge where there is no CPA in place a patient could be discharged without notice to a carer and as such care that is anticipated to be in place on discharge may not be available.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 19 July 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: The family of Mr Brown 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.
9	**20 May 2022** J. Andrews