H G Mark Bricknell
Senior Coroner
for County of Herefordshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Clinical Lead, Herefordshire and Worcestershire Healthy Minds
1	**CORONER** I am Hugh Gregory Mark Bricknell, Senior Coroner for County of Herefordshire
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 9 February 2022 I commenced an investigation into the death of Terri Ann Malone. The investigation concluded at the end of the inquest on 10 October 2022. The conclusion of the inquest was 'Alcohol Related'.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was drinking excessively and probably died from ketoacidosis as a consequence of excessive alcohol consumption, however at the time of her death she was also known and had received assistance from Adult Safeguarding, Hereford Recovery Service, The Mental Health Crisis Team, the Police and others.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) Initial contact with the service is with an inexperienced practitioner and a decision is made regarding a treatment plan without any direct contact being made by an experienced practitioner. (2) Notwithstanding the above a service user is discharged from the service if they fail to attend an appointment and do not respond to a voicemail by the end of the day. This despite the patient being required to wait several months for an appointment. (3) A decision is made to discharge the patient without establishing their current circumstances and the current (if any) input from other agencies; full details of whom and consent to share

	information could be obtained during initial instructions taken by a more experience practitioner.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, [redacted] 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 December 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. 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	24 October 2022 Signature HG Mark Bricknell, HM Senior Coroner: Herefordshire