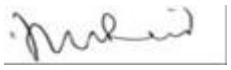
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive, Herefordshire & Worcestershire Health and Care NHS Trust
1	**CORONER** I am David Donald William REID, HM Senior Coroner for Worcestershire.
2	**CORONER'S LEGAL POWERS** I make this report under 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 [the details below are fictional]** On 27 July 2021 I commenced an investigation and opened an inquest into the death of Charlotte Comer. The investigation concluded at the end of the inquest on 17 February 2023. The conclusion of the inquest was as follows: *"Charlotte Comer died as the result of suicide. The following failings on the part of the Herefordshire and Worcestershire Health and Care NHS Trust ('the Trust') probably caused or contributed to her death: (a) The erroneous decision at the beginning of 2021 to seek to pause Charlotte's referral to the Priory Hospital for specialist treatment for Body Dysmorphic Disorder; (b) The high turnover of care coordinators for Charlotte whilst she was under the Trust's care, together with a five month period when she was without a care coordinator at all, which led to a loss of awareness on the Trust's part about the seriousness and complexity of Charlotte's needs; and (c) The failure by the Trust to provide sufficient focus on the important issue of Charlotte's Body Dysmorphic Disorder. Charlotte's death was contributed to by neglect."*
4	**CIRCUMSTANCES OF THE DEATH** In answer to the questions "when, where, how and in what circumstances did Charlotte come by her death?", I recorded as follows: *"On 18.7.21 Charlotte Comer, who lived with a number of significant mental health disorders, including Body Dysmorphic Disorder, and had a known history of attempts at suicide and self-harm, left Worcestershire Royal Hospital before doctors there could treat a substantial, recently self-inflicted wound to her upper arm. She returned initially to her parents' home, before then making her way to her own address in Worcester, where she proceeded to take a substantial overdose of Propranolol and Amlodipine medication. She was taken by ambulance back to Worcestershire Royal Hospital where, despite treatment, she succumbed to the effects of the overdose and died on the morning of 20.7.21."*
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. – (1) During the 2½ years in which Charlotte's mental health care was provided by the Trust, she had total of 8 different care coordinators. Furthermore, in those 2½ years there was a 5 month period when Charlotte had no appointed care coordinator at all. The care coordinator role is particularly important for a patient with such a complex case history as Charlotte. I heard evidence that at the time of these events, the Trust had been experiencing an unprecedented level of instability, with many staff who might have been expected to fulfil care coordinator roles going off sick or even leaving the service. The witness who had conducted the Trust's own internal investigation into these events gave evidence that one of the major reasons for this instability was that staff were unable to cope with ever-increasing workloads. The Trust's Community Services manager for the Worcestershire Neighbourhood Teams appeared to corroborate this in his evidence, confirming that whilst national guidelines recommend a maximum of 30 patients per care coordinator, at the time of these events the Trust's care coordinators had around 100 patients each. Whilst he was able to provide some reassurance that a recent recruitment drive has reduced individual care coordinator caseloads to around 25 patients, he was unable to explain how individual caseloads had been able to reach the levels they did at the time of these events, and was unable to give accurate figures as to current levels of staff sickness/absence. I am concerned that the Trust is unable to understand fully how the care coordinator system failed at the time of these events, and that it is therefore not in a position to guard against a repeat of these circumstances in the future. (2) The erroneous decision to pause Charlotte's referral to the Priory Hospital for specialist treatment for Body Dysmorphic Disorder was taken by a senior clinician acting on her own, despite a Multi-Disciplinary Team meeting having decided that the referral was appropriate. When asked about how the senior clinician could have overridden the MDT decision, the Trust's Community Services manager for the Worcestershire Neighbourhood Teams told the inquest that he could not say whether the senior clinician was not aware of the correct decision-making procedure, or whether she was, but chose instead to ignore it. When asked whether the same issue could arise in future, he told the inquest that he himself would be in a position to prevent the senior clinician making the wrong decision, but could not guarantee that he would be made aware of the issue so as to be able to do so. I am concerned that the Trust has not properly established how the senior clinician was able to override the MDT decision, and does not have a sufficiently robust system in place to ensure that MDT decisions cannot be overridden in this way in future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as Chief Executive of the Herefordshire & Worcestershire Health and Care NHS Trust, 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 **8 May 2023.** 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: [redacted] (Charlotte's parents); [redacted] Novum Law solicitors (representing Charlotte's family); [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	**13 March 2023**  **David REID** **HM Senior Coroner for Worcestershire**