ANDREW HETHERINGTON
H M Senior Coroner for North Northumberland and
Acting Senior Coroner for South Northumberland

County Hall, Morpeth, Northumberland NE61 2EF

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive of Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust**
1	**CORONER** I am Andrew Hetherington, Senior Coroner for North Northumberland and Acting Senior Coroner for South Northumberland.
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://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 10 April 2019 HM Senior Coroner Tony Brown commenced an Investigation into the death of Odessa Carey who was born on 20 May 1945 and who died within [redacted] on 8 April 2019. He adjourned and suspended the investigation under Schedule 1 of the CJA as he was informed on 15 April 2019 that an individual had been charged with a homicide offence of murder. On 11 March 2020 the perpetrator was found to have committed Murder and sentenced under Section 38 Hospital Order with a Section 41 Restriction. I made the decision to resume the Inquest, as there was sufficient reason to do so as the perpetrator had been involved with mental health services for an extensive period of time and was still open to services at the time of Odessa Carey's death. The conclusion of the inquest was "Unlawfully killed".

	The medical cause of death was 1a Blunt force head injury.
4	**CIRCUMSTANCES OF THE DEATH** Odessa Carey was last seen alive on the evening of Thursday 4th April 2019 within her home address [redacted], Ashington. She was attacked by the perpetrator. On 7th April 2019 the police have attended [redacted], Ashington and found the body of the deceased covered with bedding sheets. The body was without the head. Police officers have then attended another address and following a systematic search of that property, the perpetrator was found and arrested in connection with the murder of the deceased. On 11 March 2020 the perpetrator was found to have committed Murder and sentenced under Section 38 Hospital Order with a Section 41 Restriction. I resumed the Inquest as there was sufficient reason to do so as the perpetrator had been involved with mental health services for an extensive period of time and was still open to services at the time of Odessa Carey's death.
5	**CORONER'S CONCERNS** During the course of the inquest 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. Multi-agency Risk Assessment Conference ("MARAC")** I heard evidence of issues of assault, violence and intimidation. Further that the consent of the individual reporting the concerns is not always required in order to complete a MARAC referral. Whilst I recognise that the extent of the issues could have been diminished out of familial ties or for other reasons, I am concerned that that staff did not explore the issues to a greater extent with the deceased, the wider family and other agencies. **2. Assessment of substance misuse** The service user had a history of substance misuse in particular cannabis and its impact on mental health was recognised. Whilst I acknowledge issues regarding service user consent and compliance, I am concerned there was no referral to substance misuse services for advice or assessment and treatment whilst an inpatient or in the community. **3. Inpatient discharge 30 May 2018**

The discharge was not a coordinated discharge in line with the trust CPA policy. There was no discharge meeting, no involvement with other agencies or family, the service user was still mentally unwell, having delusional beliefs, without supported accommodation, vulnerable, moving to a new locality and without familial support

I am concerned there was a lack of opportunity to involve the family or other agencies in the discharge.

I am concerned that there was no direct contact or introduction to the service user from the care coordinator whilst an inpatient or before discharge to establish a relationship and trust.

4. Discharge from the Community Treatment Team on 6 August 2018

There was no pre-discharge meeting in line with trust CPA Policy involving the family, lead professionals, other agencies or a Consultant Psychiatrist for future planning.

A more assertive approach to engagement may have been appropriate.

I am concerned that following discharge from the Lowry ward to the community and prior to discharge from the community treatment team, the deceased was seen only four times in person by individuals from the mental health team and only once by the care coordinator.

I am concerned that more intense, in person engagement was warranted and discharge from the Community Treatment Team was premature.

I am concerned that the service user was not seen by a Consultant Psychiatrist at all after 30 May 2018 despite enquiring about a further appointment.

5. Appointment of a Care Coordinator

I heard that in line with the trust CPA policy paragraph 12.1 "*Consent must always be sought from a professional prior to them being identified as a Care Coordinator. Under no circumstances must any professional be stated as Care Coordinator without negotiation and agreement.* "

I am concerned that consent and agreement was not obtained from a care coordinator prior to being identified for the role of care coordinator and concerns regarding capacity were not considered.

6. FACE Risk assessment tool

I am concerned that there continues to be an inconsistent approach to the assessment of risk. Various methods are still being deployed and there is a possibility of a disparity in the understanding of the risk to the service user and others.

7. Record Keeping Documentation

	I am concerned that entries in the RiO medical records were not made in line with Trust guidance in a timely, complete manner or at all. I am concerned that evidence of clinical assessment, care planning and the reasoning behind clinical decision making were not recorded. **8. Contact with IRT and referral to Community Treatment Team** The service user contacted the service on a number of occasions and sought self-referral to the Crisis team on 19 September 2018 who assessed her as requiring a re-referral to the community team. No referral was made. I am concerned that there was a delay in the referral to the Community Treatment Team and there is no audit system to ensure referrals are made and in a timely fashion.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 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 Odessa Carey Deceased 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	Date 12 May 2023 Signed: A. P. Hetherington Andrew Hetherington HM Senior Coroner for North Northumberland and Acting Senior Coroner for South Northumberland