*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted], Chief Medical Officer, CPFT
1	**CORONER** I am Andrew Cox, the Senior Coroner for the coroner area of Cornwall and the Isles of Scilly.
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 21/6/23, I concluded an inquest into the death of Christopher Stevens, aged 58, who was found deceased on 11/2/22. . The medical cause of death was recorded as: 1a) Exsanguination 1b) Multiple incised wounds I recorded a Conclusion of Suicide.
4	**CIRCUMSTANCES OF THE DEATH** Chris had enjoyed a long period of relative stability with his mental health until 2020/21. In the period that followed there were two serious attempts at overdose both of which resulted in lengthy admissions into ICU. He was admitted to Longreach and was known to the in-patient team. On 6//1/23, he was admitted into RCHT following an overdose. He was then transferred to Longreach and admitted on to Perran Ward on 22/1/23 before being transferred to Carbis and Cove wards on 25/1/23 and 6/2/23 respectively. He was admitted as an informal patient and, prior to his transfer to Cove ward, had a number of episodes of escorted leave. On 8/2/23, the inquest heard that Cove ward was understaffed with only one of three rostered nurses due to attend. Accordingly, the ward manager, [redacted], came to work early to assist her nursing colleagues. While treating another patient with suspected sepsis, Chris

	requested leave to go into the hospital's grounds. [redacted] accepted in evidence she had not had time to read Chris's RiO records and she did not then appreciate that his previous leave had only been escorted. She delegated to an HCA, in effect, to check that leave was appropriate before authorising it without conducting her own assessment of risk. There was a short delay in appreciating that Chris had not returned to the ward as anticipated. His body was discovered three days later.
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 Trust has conducted a PSIR the contents of which were reviewed at inquest. The report reached conclusions I found entirely reasonable. I also heard from [redacted] about the steps that are being taken to implement the changes felt to be appropriate. This includes a change to the consultant model with one consultant now responsible for the individual wards. There is also an initiative to standardise documentation, for example, at handover, and later MDT (when risks are reviewed), to ensure this is incorporated into RiO, together with an express intention to involve the family in decision-making. It was accepted that risk should be assessed by a nurse prior to granting leave to an informal patient particularly where unescorted leave is being considered for the first time. Although Chris's death occurred in February 2022, it also became clear that the process had not been completed. It was hoped this could be achieved by the end of July this year but the inquest was told there would need to be consideration of the proposals by the different consultants now involved. I was concerned to ensure that the process was completed without undue delay and it is with this in mind that I now write to you.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 20 August. 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] – cousin of Chris; 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] 22.6.23** **[SIGNED BY CORONER]**