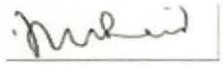
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1) The Chief Executive, Herefordshire & Worcestershire Health and Care NHS Trust, 2 Kings Court, Charles Hastings Way, Worcester WR5 1JR; 2) The Chief Executive, Gloucestershire Health & Care NHS Foundation Trust, Edward Jenner Court, 1010 Pioneer Avenue, Gloucester Business Park, Brockworth, Gloucester, GL3 4AW.
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 2022 I commenced an investigation and opened an inquest into the death of Nigel Harper. The investigation concluded at the end of the inquest on 15 May 2023. The conclusion of the inquest was that Mr. Harper died as the result of suicide.
4	**CIRCUMSTANCES OF THE DEATH** In answer to the questions "when, where and how did Mr. Harper come by his death?", I recorded as follows: "On 8.7.22 Nigel Harper, who had over the previous month been experiencing severe depression and anxiety, and living with thoughts of self-harm, took an intentional overdose of prescribed sedative and hypnotic medications. He was taken to Worcestershire Royal Hospital where, despite treatment, he continued to decline, and died on 23.7.22." Mr. Harper lived in Scotland, but in the period leading up to his death had been staying with his sister near Malvern. He had a lengthy mental health history, which included a recent inpatient admission to a psychiatric hospital in Edinburgh.
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) On 4 July 2022 Mr. Harper attended the Emergency Department at Gloucester Royal Hospital, and was seen by a nurse from the Mental Health Liaison team there, who recorded that he was very anxious and distressed, and voicing ongoing thoughts of suicide. The nurse felt that Mr. Harper would benefit from a

	period of treatment under the care of the Home Treatment Team, and because Mr. Harper was living in Worcestershire at the time, and because it was now in the early hours of the following day, he called the Worcestershire Crisis Team to arrange that. The nurse concerned was under the impression that by making this phone call, and passing on Mr. Harper's details to the Crisis Team, he was referring Mr. Harper's case to them. He told the inquest that he was expecting mental health services in Worcestershire to arrange a further urgent assessment of Mr. Harper, and he therefore ensured that Mr. Harper was told to expect the Crisis Team to contact him to arrange a further assessment. (2) The Clinical Lead for the Crisis Team in Worcestershire gave evidence to the inquest that whilst the Crisis Team did receive a request from the nurse at Gloucester that night, they interpreted it only as a request for further assessment (but not an urgent one), and not as a request that Mr. Harper be referred to the Home Treatment Team. (3) In the event, an urgent assessment was not arranged, and Mr. Harper's case was only considered by the Home Treatment Team in Worcestershire when his temporary GP in Worcestershire, out of further concern for Mr. Harper's mental health, made a new and separate referral to them. (4) I have concluded that the events described above arose out of a lack of understanding between the two NHS Trusts concerned (Herefordshire & Worcestershire Health and Care NHS Trust (HWHCT) and Gloucestershire Health and Care NHS Trust (GHCT)) as to how each other's mental health services are run – otherwise arrangements would have been made for Mr. Harper's mental health to be assessed urgently, as was intended. (5) If staff at HWHCT and GHCT do not understand how to make urgent mental health referrals or requests for urgent mental health assessments to each other, there remains a risk that other deaths may occur in similar circumstances in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as the Chief Executives of HWHCT and GHCT 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 **28 July 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] (Mr. Harper's widow); [redacted] (Mr. Harper's sister). I am also under a duty to send the Chief Coroner a copy of your respetive responses. 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	**2 June 2023**



David REID
HM Senior Coroner for Worcestershire