**ANNEX A**

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

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

| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>1. **Devon Partnership NHS Trust**<br>2. **[redacted] Langdon Hospital**<br>3. **[redacted] [redacted] , Langdon Hospital** |
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| 1 | **CORONER**<br><br>I am Deborah Archer , Assistant Coroner, for the Coroner area of Plymouth , Torbay and South Devon |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 7th August 2020 I commenced an investigation into the death of Paul Perrott , age 34 The investigation concluded at the end of a jury inquest on 17th November 2023 .The conclusion of the inquest was suicide but the jury answered a number of questions which raised concern over the level of observations and care given to Paul during his time on Ashcombe Ward. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mr Perrott was an inpatient on Ashcombe Ward , Langdon Hospital detained in hospital under sections 37 and 41 of the Mental Health Act 1983 . He had spent most of his adult life in psychiatric hospital and had a recent history of self harm in that he had attempted to hang himself [redacted] on 20th May 2020 before finally succeeding in carrying out the exact same act on 31st |

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| | July 2020 which this time resulted in his death. Mr Perrott was on 15 minute observations at the time of his death but these were not recorded and no one noticed he was missing until 15 minutes after his death . |
| 5 | **CORONER'S CONCERNS**<br><br>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows. –<br>Despite the Trust having prepared a detailed report and addendum for my consideration after the inquest I am still concerned about the following :<br>(1) Paul Perrott's observations charts were not filled out adequately or at all on the date of his death<br>(2) There appeared to be a lack of clarity over who was responsible for checking the observation charts ,when they would be checked by staff over the course of a working day and who would regularly feed back to staff if there was a problem in this respect .<br>(3) At least one member of staff was unaware that Paul had described himself to staff in May 2020 as looking for an opportunity to take his own life if it arose and that Paul had attempted to take his own life less than 3 months previously in exactly the same way as on 31st July 2020.<br>(4 ) Although certain changes to policy and procedures were described to me there still seems to be a focus on risk in the "here and now "which does not include an analysis of historical and contextual risks |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>Although there have already been changes made to polices and procedures in the hospital arising out of this death action should be taken:<br>• To review the procedures in place on the wards to ensure that observation charts are regularly checked by ward management and concerns feedback to staff quickly and appropriately<br>• To ensure that staff members are required and able to easily familiarise themselves with the full history in relation to each patient they care for as opposed to simply being made aware of any risks that present on the day which may not take account of historical or contextual risk .<br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, |
| | namely by 5th February 2024 . I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested<br>Persons : [redacted] ( Brother of the Deceased )<br>I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.<br><br>I may also send a copy of your response to any other person who I believe may find it useful or of interest.<br><br>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.<br><br>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response. |
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| 9 | **[DATE]** 11.12.23 **[SIGNED BY CORONER]** J. Archer |