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

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

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. Chief Executive, West London NHS Trust** |
| 1 | **CORONER**<br><br>I am Lydia Brown, Acting senior coroner, for the coroner area of West London |
| 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 15 October 2021 I commenced an investigation into the death of Tom Sweeting, age 51. The investigation concluded at the end of the inquest on 20 December 2023.<br><br>Medical cause of death -<br>1a Cerebral hypoxia<br>1b Hanging<br><br>The Conclusion was as follows:-<br><br>suicide |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Tom suffered a sudden acute deterioration in his mental health, exhibiting signs of a depressive disorder in August 2021. He sought medical assistance and was assessed by the Hounslow liaison psychiatry service on 18th August. At that time he did not disclose any plans to take his own life, but did confirm he was having suicidal thoughts and thoughts that he could not continue living. Due to poor communication from the hospital to the General Practise, the intended prescription for antidepressant medication was not provided. On 20th August 2021 Tom locked himself in the garage at home, [redacted] and was found later that morning suspended by ligature. Resuscitation attempts were unsuccessful. |

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| A st | **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><br>1. Tom was assessed in relation to his mental ill health presentation by the Consultant liaison psychiatrist, but the Trust template was not completed, which was not in compliance with the Trust policy and criticised in the Trust serious incident report. There is a concerning mismatch of what more junior colleagues are expected to do and be trained in, compared with Senior practitioners demonstrated work practises.<br>2. No letter of discharge was sent at the time Tom was seen by the liaison psychiatry team, and a letter was only generated in response to investigations taking place after the death. The team acknowledged that there were "problems" with sending out letters at the time, and no evidence was brought before the court that this issue has now been resolved. Letters should be dispatched within 24 hours of attendance. Communication between the various community teams and setting out the treatment plan to the patient are important factors that were not effective during Tom's care and remain a concerning omission where there may be a simple and effective remedy.<br>3. It was acknowledged that obtaining collateral information from the family is vital, but in this case was delegated to a very Junior member of the team who was in the early stages of her training. It should be considered if this task is appropriate to delegate, and if so what information should be sought from families/carers and how that should be effectively used to support patient care.<br>4. The Trust showed good intentions of reviewing the training programme, but were unable to evidence that planned 6 monthly audits had actually taken place, and so there was no evidence before the court that the new training that had arisen from the serious incident findings was effective. Introducing new training, templates and supervision performance appraisals all seem to be positive interventions, but in the absence of any process to audit their effectiveness, it is concerning that the Trust have no way in which to judge their impact. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, |

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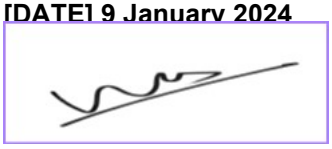
| | namely by 6 March 2024. I, the coroner, may extend the period.<br><br>Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed. |
| 8 | **COPIES and PUBLICATION**<br><br>I have sent a copy of my report to the Chief Coroner and to the local safeguarding board where the deceased was under 18 and to the following Interested Persons<br>Family members<br>[redacted] – friend<br>[redacted] – GP<br>[redacted] – GP<br>London Ambulance Service<br><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. |
| 9 | **[DATE] 9 January 2024** **[SIGNED BY CORONER]**<br>  |