Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **Berkshire Healthcare NHS Foundation Trust** **Cygnet Hospital, Harrow** **Reading Borough Council Adult Social Care**
1	**CORONER** I am Alison MCCORMICK, Assistant Coroner for the coroner area of Berkshire
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 27 May 2022 I commenced an investigation into the death of Sarah Elizabeth ADAMS aged 64. The investigation concluded at the end of the inquest on 18 March 2024. The conclusion of the inquest was that: **Ms Adams died by suicide; however, her death was more than minimally contributed to by care and service delivery issues around her discharge from a voluntary in-patient hospital admission for a relapse of her longstanding paranoid schizophrenia and an intentional medication overdose.**
4	**CIRCUMSTANCES OF THE DEATH** Sarah Adams was found deceased at her home address on 19th May 2022. She died from a self administered overdose of prescribed medication taken with the intention of ending her life. On the balance of probability Ms Adams' death was more than minimally contributed to by care and service delivery issues around her discharge on 18th May 2022 from a voluntary in-patient hospital admission for a relapse of her longstanding paranoid schizophrenia and an intentional medication overdose taken on 4th April 2022. Specifically, a misunderstanding about the Crisis Team visiting Ms Adams on the day of her discharge together with the provision of 5 days of prescribed medication to her likely made a more than minimal contribution to her death. The following care and service delivery issues possibly made a more than minimal contribution to Ms Adams' death: (a) Delay by the mental health Trust in actioning the care plan on Ms Adams' discharge from the Crisis Team in October 2021, both in respect of allocating a Care Co-ordinator to her and in arranging an Out Patient Appointment and medication review; (b) The mental health Trust's response to Ms Adams' deterioration in February and March 2022.
5	**CORONER'S CONCERNS**

	During the course of the investigation my inquiries 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. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) That clinicians and other hospital, mental health Trust and Social Care practitioners involved in the discharge of patients from in-patient mental health admissions are not trained in the discharge process generally and specifically the issues which may arise in respect of out of area admissions
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 May 15, 2024. 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 I have also sent it to Sarah Adams's Family who may find it useful or of interest. 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. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 21/03/2024** Alison McCormick **Alison MCCORMICK** **Assistant Coroner, Berkshire for Berkshire**