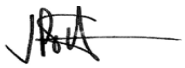
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] Chief Executive, Midlands Partnership Foundation Trust
1	**CORONER** I am Mr John Penhale Ellery, Senior Coroner, for the coroner area of Shropshire, Telford & Wrekin.
2	**CORONER'S LEGAL POWERS** I make this 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 2nd May 2018 I commenced an investigation into the death of [redacted] 18 years of age, and opened an inquest on the 10th May 2018. The investigation was concluded at the end of the inquest on the 14th and 15th November and 17th December 2018. [redacted]. The conclusion of the inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** [redacted] was found deceased [redacted]. She was found [redacted] had mental health issues starting from around 15 to 16 years of age. They resulted in self-harm and 2 suicide attempts the last of which was in September 2017. Mental health care had been provided to [redacted] both before and after her 18th birthday [redacted]). She was in contact with mental health services up until the evening of the 30th April 2018 before she killed herself the next morning.
5	**CORONER'S CONCERNS** On the evidence various issues were addressed and set out in the coroner's determination and findings and can be referred to for wider reading. Two specific issues arose which could not be said to have caused or contributed to [redacted] death but could in others. 1 <u>Delay in IAPT counselling</u> a) After [redacted] turned 18 she moved to adult mental health services. She had parallel contact with her GP surgery [redacted]. Shortly before [redacted] 18th birthday, according to the MPFT clinical review (page 9 of 33), [redacted] was referred to Improving Access to Psychological Therapies (IAPT) by the [redacted] Access Team for assessment for psychological therapy or counselling. On the 14th November 2017 (page 12 of 33) it was agreed with [redacted] to add her to her GP surgery waiting list for counselling in line with her treatment preference. [redacted] remained on the IAPT waiting list for counselling at the time of her death. b) The evidence at the inquest was that a 3 month time interval would be optimal but in [redacted] case, in relation to this GP surgery, 10 months would be the norm. Such a delay is sub-optimal and could have an adverse effect on a

	patient waiting for counselling to commence. 2. <u>Risk assessment and progress notes</u>. a) The electronic records were hard for a lay person to follow or understand particularly when said to have been updated or validated with the potential for original entries to have been overwritten (as opposed to amended or deleted). If the user of the system understands it then that does not make it unfit for purpose but it was not clear how a user would readily see what had originally been written. b) This is distinct from progress notes and/or risk assessments being accurately recorded. It was not clear when and how often risk assessments should be updated and how and when they would be read in conjunction with the progress notes. Were risk assessments intended to be summaries if a user did not have time to read all the progress notes? What function were they intended to serve? Consideration should be given as to whether the system can be improved.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 15th February 2019. 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 • Lanyon Bowdler solicitors for [redacted], mother of [redacted]. • [redacted], father of [redacted] • [redacted], brother of [redacted] • [redacted], legal representative of the MPFT • [redacted],[redacted] 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	 Mr John Penhale Ellery Senior Coroner Shropshire, Telford & Wrekin 21st December 2018