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:** **1 Spider Project Cafe 71** **2 Cheshire & Wirral Partnership NHS Foundation Trust (CWP)** **3 West Cheshire Clinical Commisioning Group**
1	**CORONER** I am Victoria DAVIES, Area Coroner for the coroner area of Cheshire
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 08 December 2021 an investigation was commenced into the death of Evie Jane DAVIES aged 25. The investigation concluded at the end of the inquest on 01 May 2024. The conclusion of the inquest was one of suicide.
4	**CIRCUMSTANCES OF THE DEATH** Evie Jane Davies was found deceased [redacted] at home on 2 December 2021 having taken a significant overdose of medication which had not been prescribed to her. It is likely that this was a deliberate act with the intention to end her life, contributed to by a deterioration in her mental health which commenced in June 2021 following the unexpected death of her partner, and was compounded significantly over the following months by on-going family proceedings regarding her children, lack of regular contact with her children and a forthcoming criminal hearing which she perceived would also impact upon her ability to be with her children. In the 6 month period prior to her death, Evie was being supported by the mental health team (part of CWP), had an allocated care co-ordinator until November 2021, and in the last few weeks before her death was under the home treatment team. The mental health team supporting her were aware of her on-going stressors and that 3 December was a key date for Evie, the anticipation of which was significantly affecting her mood. On 1 December Evie received some unwelcome news. It is described by the GP that she called the crisis line and was directed to the cafe71 service. There were no notes of this call available to the inquest as the pro forma supplied to the GP is blank but it is likely, given what we know of the background circumstances and the susbequent events, that she shared some distress during this call.
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) The evidence I heard was that the café71 service is run as a crisis line for those who are in 'lesser crisis' than those who would call the mental health team crisis line or the crisis resolution home treatment team. It appears that the cafe71 team is operating in isolation/ separately to the mental health team, and for those patients who are under the mental health team, they will be unaware of the background and the risk factors for that person. They will take an assessment of that person at face value based on how they are in the call, as they don't have access to the information held by the mental health team. In addition, there does not appear to be any notification to the mental health team to say that the person has been in contact such that this can be followed up. It is likely that there is notification to the GP but in this case there was no detail provided which could have been passed on, and the timescales for review of correspondence by the GP, who again are operating somewhat in isolation to the mental health team, does not lend itself to the prompt action which may be required by the mental health team. I am concerned that the lack of information sharing between the organisations, and in particualr in real time or as near as possible, gives rise to a risk of future deaths and consider that your organisation has the power to take action, either as provider of the service or as commissioner.
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 June 27, 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 **Evie's family, specifically** [redacted] **Cheshire Constabulary** **Cheshire West & Chester Council** 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: 02/05/2024**

	 **Victoria DAVIES** **Area Coroner for** **Cheshire**