Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Chief Executive, Oxford Health NHS Foundation Trust**
1	**CORONER** I am HEIDI J CONNOR, Senior Coroner for Berkshire 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. It is important to note the case of *R (Dr Siddiqui and Dr Paeprer-Rohricht) v Assistant Coroner for East London*. This case clarifies that the issuing and receipt of a Regulation 28 report entails no more than the coroner bringing some information regarding a public safety concern to the attention of the recipient. The report is not punitive in nature and engages no civil or criminal right or obligation on the part of the recipient, other than the obligation to respond to the report in writing within 56 days.
3	**INVESTIGATION** The family requested me to refer to the deceased as Jai. I will reflect that in this report. I conducted an inquest into the death of Jai which concluded on 21st of November 2024. I recorded a conclusion of suicide.
4	**CIRCUMSTANCES OF THE DEATH** Jai was a 36 year old GP. She was found deceased on 27th of April 2023. I have not detailed all of Jai's contact with mental health services in this report. Instead, I have focused on aspects of the chronology which are relevant to the concerns I am raising. Jai referred herself to the Crisis Response and Home Treatment Team ("the crisis team") on 21st of June 2022. She attended three appointments in June and July 2022, and was discharged from the crisis team to Buckinghamshire Talking Therapies ("BTT")

	on 29th of July 2022. Whilst under this team, Jai disclosed that she had made previous suicide attempts. From August 2022 onwards, the mental health support that Jai received was from teams other than BTT. These teams used a different electronic records system (called Rio). They are part of the same NHS trust, but it was not possible for clinicians to access both systems. After an attempt to refer Jai to the crisis team (by her GP) on 31st of August 2022, Jai was provided with an appointment date with the community mental health team. The appointment date was 8th of September 2022. Before that appointment could happen, Jai attended accident and emergency (after being encouraged to do so by friends and her GP). She was then admitted as a voluntary patient to a psychiatric ward, until 7th of September 2022. After she was discharged, Jai was under the crisis team for around 10 days. After that, no medium or long term plan was put in place, and she was discharged back to the care of her GP. Jai took her own life in April 2023. She was not under secondary mental health services at the time of her death.
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: 1. The Trust's own internal investigation highlighted the fact that no care co-ordinator or key worker was provided to Jai after her discharge from hospital on 7th of September 2022. The Trust's initial plan was to review this by June 2024, and the aim now is for January 2025, almost two years from Jai's death. 2. It is still not possible for teams using RiO and the BTT systems to access each other's clinical notes.
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 January 20, 2025. 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 Jai's family, via their legal representative. I have also sent this report to the following recipients who have an interest in this matter: 1. NHS England – I consider that these issues are likely to be national rather than only local; 2. Legal representative for the GP practice involved in this case; and 3. [redacted] Senior Coroner for Buckinghamshire, as a matter of courtesy. who may find it useful or of interest. 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	**Dated: 25/11/2024**  **HEIDI J CONNOR** **Senior Coroner for Berkshire for Berkshire**