REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Vice Chancellor of Arts University Bournemouth** **2. The Chief Executive of Dorset Healthcare NHS Foundation Trust** **3. The Chief Executive of Devon Partnership NHS Trust**
1	**CORONER** I am Richard T Middleton, Assistant Coroner, for the Coroner Area of Dorset
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 the 1st February 2022, an investigation was commenced into the death of Alexander Kieran Ari Channing (known as Alec), born on the 17th July 2003. The investigation concluded at the end of the Inquest on the 18th December 2024. The Medical Cause of Death was: 1a Hanging The conclusion of the Inquest recorded that Alexander Channing died as a consequence of suicide in circumstances where decisions were made at the time of discharge from hospital on 19/1/22 not to involve the Home Treatment Team and to postpone a Community Mental Health Team meeting on 25/1/22 which has led to missed opportunities to reassess his risk of suicide, the last missed opportunity being two days before his death.
4	**CIRCUMSTANCES OF THE DEATH** In 2021 Alec had been diagnosed with Emotionally Unstable Personality Disorder. He had been detained in hospital under s.2 of the Mental Health Act 1983 between 29/7/21 and 11/8/21. Following discharge he was seen by the Home Treatment Team and then the Community Mental Health Team. There was a delay in the transfer of care from the Community Mental Health Team based where his family lived to the Community Mental Heath Team in his university town.

	It was believed that the transfer could not take place until he had registered with a GP surgery in his university town. The referral was opened by the new Community Mental Health Team on 24/11/21. Alec was detained in hospital under s.2 of the Mental Health Act 1983 between 7/1/22 and 19/1/22. On discharge a decision was made not to involve the Home Treatment Team. An appointment was fixed for Alec to meet with the Community Mental Health Team on 25/1/22 for an assessment. Alec contracted Covid on or around 25/1/22 and the assessment meeting was postponed as it was deemed necessary for there to be a face to face assessment. On 27/1/22 Alec was found suspended by a ligature in his room at his university halls of residence. Paramedics attended and pronounced him dead at the scene. Dorset Police investigated and found no suspicious circumstances.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: 1. During the inquest evidence was heard that: i. The number of students commencing or resuming studies following the Covid 19 pandemic with mental health issues and requiring support from the wellbeing services at Arts University Bournemouth has significantly increased. ii. Alec was to be transferred from the Community Mental Health Team in his home town to the Community Mental Health Team in his university town. The transferring CMHT were unaware that it was possible to arrange a direct transfer to the receiving CMHT without the need for Alec to be first registered with a GP surgery in his university town. iii. Alec was admitted to a district hospital on 7/1/22 and seen by the Liaison Psychiatry Team. Following a decision to discharge Alec from hospital it was decided that a referral to the Home Treatment Team was unnecessary. Alec was discharged to a date provided by the CMHT in his university town. There was no involvement of that CMHT in his discharge planning. iv. Alec had initially indicated that he would consent for information to be shared with others but that consent was withdrawn. There was no pro active approach taken by the CMHT in his home town to seek his consent to share information. 2. I have concerns with regard to the following: i. There is no training provided to the wellbeing services at the Arts University Bournemouth in relation to students diagnosed with Emotionally Unstable Personality Disorder.

	ii. There appears to be a failure amongst staff at the Exter CMHT to appreciate that there can be a direct transfer of a patient's care to another CMHT Trust without the need for a patient to have to first register with a GP surgery iii. There was a lack of involvement of a responsible clinician in the process of discharge planning from the district hospital in Exeter to the care of Bournemouth CMHT at Dorset Healthcare NHS Foundation Trust. iv. There is no policy in place at Devon Partnership NHS Trust which encourages a repeated proactive approach in seeking consent from a patient to share information at relevant times.	
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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, 28th March 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 the following Interested Persons: (1) Alec's family 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** **31st January 2025**	**Signed** **Richard T Middleton**