Regulation 28: Prevention of Future Deaths report Caroline Harris (died on or before 27/07/2023)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Director of Adult Social Services, Oxfordshire County Council
1	**CORONER** I am Nicholas Graham, HM Area Coroner, for the coroner area of Oxfordshire.
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 31 August 2023 an Inquest into the death of Caroline Diane Harris was opened. Her body was found on the 26 July 2023 at her home address. An investigation was commenced and concluded at the end of the inquest on the 27 June 2024
4	**CIRCUMSTANCES OF THE DEATH** Ms. Harris was 51 years old when she was found deceased at her home address on 26 July 2023. She was found in the bathroom in an advanced state of decomposition. A post-mortem examination was carried out on 3 August 2023. A medical cause of death could not be ascertained. I reached a Narrative Conclusion as follows: *'Caroline Harris had a long-standing diagnosis of severe mental illness. In August 2022, she refused to continue taking her monthly antipsychotic medication, and her mental health deteriorated. Information relating to Ms. Harris' decision to stop taking her medication, as well as concerns raised by Thames Valley Police about a decline in her mental health, was not passed on to the Adult Mental Health Team. Consequently, they were unable to supervise her adequately. On 26 July 2023, Caroline was found deceased at her home. Although it has not been possible to ascertain a medical cause of death due to decomposition, it is likely that she died from a natural cause, exacerbated by self-neglect.'* Caroline attended a monthly clinic to receive her antipsychotic medication. Evidence was given that at the time there was no clear process for passing information onto the Adult Mental Health Team (AMHT) should patients not attend and/or decline to take their medication. Had the AMHT been notified then evidence was given that they would have undertaken intensive and assertive follow up. Nor was Caroline's GP notified of this development. Oxford Health NHS Foundation Trust have reviewed their operating procedures to address these concerns.
5	**CORONER'S CONCERNS**

	During the course of the inquest the evidence 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. – In March 2023, Thames Valley Police passed on a report about Caroline to the Mult-Agency Safeguarding Hub (MASH) which raised concerns about her behaviour and mental state and dishevelled appearance. The report stated that it was, 'Shared in the interests of safeguarding as may be having relapse'. MASH undertook a review of the report and concluded that Caroline was not at risk but may have needs for care and support from the local authority. The information was passed to the Council's Adult Social Care Team who in turn passed the information onto Caroline's GP. Evidence was given that the Adult Social Care Team were unable to directly refer to AMHT, even if they had considered it necessary. As the GP was not made aware that Caroline had declined to attend the clinic to receive her medication, she saw no need to refer the Police report to AMHT. Evidence was given that AMHT took a different view regarding the Police report and would have viewed the report as evidence of Caroline relapsing. AMHT's view was that such a report met the criteria for being shared with them, and with their knowledge of Caroline's past history of self-neglect and non-compliance with taking medication, it ought to have been shared with them; and had it been done so it would have been followed up assertively and urgently including undertaking home visits and the possible use of compulsory powers under the Mental Health Act. My concern is that important information regarding a deterioration in mental health was not shared with the appropriate Team who may have been able make appropriate interventions and to have taken steps to avoid a fatal outcome. You should consider a review of how such information is assessed and shared between the respective agencies.
6	**ACTION SHOULD BE TAKEN** In the Coroner's opinion, action should be taken to prevent future deaths, and the coroner believes that your organisations 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 27 August 2024**. I, the Area 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 • The family of Ms. Harris • Ms Harris' GP • Oxford Health NHS Trust • The Chief Constable, Thames Valley Police 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 other 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.	
9	 **02/07/2024**	**Mr N Graham** **HM Senior Coroner**