REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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	THIS REPORT IS BEING SENT TO:
	Kent and Medway NHS and Social Care Partnership Trust
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1	CORONER
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	I am Patricia Harding, senior Coroner, for the Coroner area of Mid Kent and Medway
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 23 rd May 2012 I commenced an investigation into the death of Ricky Anderson. The investigation concluded at the end of the inquest on 27 th August 2013. The conclusion of the inquest was that Ricky Anderson killed himself while suffering from depression by means of suspension
4	CIRCUMSTANCES OF THE DEATH
	On the 29 th March 2012 Ricky Anderson was informally admitted to hospital experiencing command hallucinations with suicidal thoughts. As his symptoms coincided with substance misuse it was felt they were drug related rather than representing psychotic illness. He was discharged on the 5 th April 2012 but readmitted two days later when his symptoms returned. He continued to express suicidal and delusional thoughts intermittently whilst at hospital and was discharged earlier than planned on the 16 th April 2012 with medication which had improved his symptoms. He went to stay with a relative for a short time but did not see anyone from the Access team after his return to the area. On the morning of the 21 st May 2012 Ricky Anderson was found at Chatham Cemetery suspended from a tree. There was no evidence of third party involvement, a note in his handwriting was found on his person indicating his reasons for taking his life.
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 will 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) It was established in evidence at the inquest that practitioners from the Kent and Medway NHS and Social Care Partnership Trust did not inform Mr. Anderson's GP of his involvement with primary care on either occasion he was admitted to hospital, resulting in him not being able to obtain a further supply of medication without the intervention of his family
- (2) Evidence was given at the Inquest that following Mr. Anderson's discharge from hospital a number of attempts were made to contact him to assess his wellbeing and needs. Although Mr. Anderson was spoken to briefly, it was accepted by the Trust that too much reliance was placed on information from family members. As a result Mr. Anderson had virtually no contact with the Access team prior to his death. I understand that a practice note has recently been drafted which is intended to be used as guidance

Mr. Anderson's discharge from hospital occurred at an earlier stage than had been planned as he wished to leave and was deemed safe to do so. As a consequence, a care plan had not been put in place to establish his needs. I heard evidence that following Mr. Anderson's death procedures have been put in place to ensure that this situation does not reoccur

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe 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 %th October 2013. 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 Person

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 [DATE] 9th September 2013 [SIGNED BY CORONER] PHUCL