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. [redacted] **Managing Director** **Avon and Wiltshire Mental Health Partnership Trust** **Jenner House, Langley Park Estate, Chippenham** **Wiltshire SN15 1GG**
1	CORONER I am Terence G. Moore, Assistant Coroner, for the area of Avon
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. [HYPERLINKS]
3	INVESTIGATION and INQUEST On 13th September 2012 I commenced an investigation into the death of **Felix Stefan CEMBROWICZ** , Aged **32**. The investigation concluded at the end of the inquest on 3rd September 2013. The conclusion of the inquest was Ia Hanging **CONCLUSION: Felix took his own life whilst awaiting a planned mental health assessment, following deterioration in his mental health**
4	CIRCUMSTANCES OF THE DEATH Mental health problems and being seen by mental health team. Found hanging at HA, admitted to Bristol Royal Infirmary,, deteriorated and died
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. – The electronic Rio record system used by staff to access patient histories was introduced in May 2011 when only the documentation for current patients at that date was migrated across to the new system. Discharged patients, with both a long and recent history of contact with mental health services do not appear to have had important records transferred including relapse management plans leaving staff unaware of a patients history or delaying assessments until old records can be obtained.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you and 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 7th November 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.. I have also sent it to [redacted] 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]** **[SIGNED BY CORONER]** **12th September 2013** **Terence G. Moore**