ANNEX A

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] **2.** [redacted] **3. Royal Cornwall Hospital Trust** **4.** [redacted] **The Medical Centre, Stratton, Bude, Cornwall**
1	**CORONER** I am ANDREW COX, Assistant Coroner, for the coroner area of Cornwall
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 24 August 2012 I commenced an investigation into the death of JULIA SHIREEN DELL then aged 45. The investigation concluded at the end of the inquest on Monday 13 January. The conclusion of the inquest was that was Mrs Dell took her own life. She died of multiple injuries having been witnessed to jump from cliffs at Duckpool Beach, Kilkhampton, Bude in Cornwall
4	**CIRCUMSTANCES OF THE DEATH** I found that the cause of Mrs Dell's death was multifactorial. I found that the initiating and most significant event was the collapse and then liquidation of the family business. Other contributory features included: (A) An increasing realisation that her children were leaving home; (B) The fact that her parents had recently informed her they intended to move to St Albans; (C) Pressures relating to her work; (D) A feeling of being controlled by family members; (E) Confusion and/or a lack of compliance in taking the medications prescribed to her (F) Difficulties in her marital relationship; (G) The probability that she was suffering from a form of bi-polar disorder.
5	**<u>CORONER'S CONCERNS</u>** 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. At the inquest I found that the medical service Mrs Dell had received from primary care during the period from July 2011 until 4 April 2012 had been exemplary. This included the period from mid December 2011 until mid April 2012 when responsibility for Mrs

	Dell's care passed to Cornwall Partnership NHS Foundation Trust. I was told that on 4 April 2012 Mrs Dell decided to change GP within the practice and her care then passed to [redacted] and [redacted] who job share. In the period from 4 April until Mrs Dell's death on 22 August there was only one further contact with primary care. At inquest, [redacted] conceded that: "it would have been nice for there to have been more involvement from primary care after April 2012". He indicated also that the surgery was unaware of Mrs Dell's fluctuating mood from April until her death. The **MATTERS OF CONCERN** are as follows. – (1) There appears to have been no formal hand over between [redacted] to [redacted] in early April 2012. (2) On 19 April 2012 a care plan was received from the Community Mental Health Team following Mrs Dell's discharge from their care back to primary care. No action seems to have been taken upon its receipt. It appears as though the doctors have accepted the reassurance of the CPN that Mrs Dell's moods had stabilised on the medication prescribed to her not withstanding the fact that only three weeks previously on 22 March 2012 [redacted] had contacted [redacted] to express his concerns over Mrs Dell's wellbeing
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. In particular, I would ask you to consider whether it is appropriate to have a formal handover where patients pass from one doctor to another within the surgery. This would seem more relevant where there are urgent or ongoing medical problems. I would also ask you to consider whether it is appropriate, on all occasions, simply to place reliance upon a discharge letter and care plan without additional enquiry. That seems to be particularly the case where a discharge takes place in circumstances that appear at odds with the knowledge known to the doctors within the surgery.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Friday, 14 March 2014. 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 Interested Persons listed at the head of this letter. 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	**17th January 2014** **Andrew Cox, Assistant Coroner**