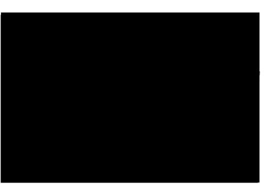
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **Chair of Clinical Commissioning Group for Wandsworth,** **Watershed House,** **1, Adelaide Road,** **London.** **SW18 1DA.** 2. [redacted] **Medical Director,** **South West London and St George's Mental Health NHS Trust,** **Springfield Hospital,** **Glenburnie Road,** **London.** **SW17 7DJ.** 3. **Mr David Bradley,** **Chief Executive,** **South West and St George's Mental Health NHS Trust,** **Springfield Hospital,** **Glenburnie Road,** **London.** **SW17 7DJ.**
1	**CORONER** I am Dr Fiona Wilcox, Senior Coroner, for the coroner area of Inner West London
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 Friday 16th August 2013 I commenced an investigation into the death of Mr Philip Anthony Dean, aged 65 years. The investigation concluded at the end of the inquest on 9th April 2014. The conclusion of the inquest was: Medical Cause of Death 1 (a) Drowning. How, when and where and in what circumstances the deceased came by his death: ***Mr Philip Dean suffered with chronic depressive illness. From June 2013 until his death, he suffered an exacerbation of this illness and became suicidal. He was referred to the Home Treatment Team and had a short admission to Springfield***

	Hospital between 9/8/2013 and 12/8/2013. On the 13/8/2013, he jumped from Battersea bride into the River Thames. He was recovered from the water and resuscitated, but unfortunately could not be saved and was recognised life extinct at Chelsea and Westminster Hospital the same morning. ***With hindsight his death at this time was potentially predictable and therefore preventable. The recognition of his suicidality may have been hampered by the lack of continuity in the secondary psychiatric care services.*** Conclusion of the Coroner as to the death ***He took his own life whilst suffering from depressive illness.***
4	**CIRCUMSTANCES OF THE DEATH** Whilst the HTT was caring for Mr Dean, he only saw the same person on 2 occasions. Mr Dean therefore had no opportunity to develop any meaningful therapeutic relationships with the HTT. This may be why Mr Dean chose not to share suicidal intent with the professional who saw him the evening before he took his own life, based upon information gained from Mr Dean's family. The HTT has no system of designated worker to provide such continuity. Mr Dean had to be discharged from the HTT to allow referral to psychology services, leaving him with only a crisis line number in the interim, but no ongoing planned intervention. His GP was the one NHS health care professional with whom he had ongoing contact and knew him best. On 9th August 2013, his GP arranged for police to attend Mr Dean and take him to hospital if necessary under a section 136, since Mr Dean was in a park with a knife and expressing active suicidal intent. This was on top of on the 6th August describing to his GP a method of suicide in his contemplation that turned out to be how he took his life. On the same day, Mr Dean expressed no ideation to the HTT. On 9th August, his GP also telephoned psychiatric liaison at St Georges and stated that in his view Mr Dean should be assessed for section. This was not recorded in his notes and further Mr Dean was not seen by anyone who could have performed such an assessment. Neither was this information passed to the psychiatrist who subsequently allowed him to go home on the 12th August 2013, who thus made this decision without the benefit of the opinion of the GP. Mr Dean had not seen by a doctor until the following day, despite the circumstances of his admission and then only by a junior SHO, who had no prior knowledge of Mr Dean and no access to the GP's concerns. The SHO records in the note that his assessment was limited to clerking essentials only due to pressure of work. The SUI into this death did not demonstrate insight into any of the pertinent issues and was thus inadequate and unhelpful
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. The **MATTERS OF CONCERN** are as follows. – (1) That the HHT is not sufficiently funded to allow continuity of care and named designated workers.

	(2)That discharge from the HTT is required before referral to psychology can be made, leaving patients without ongoing support in the interim. (3) That liaison psychiatry does not record pertinent information such as GP recommends section, this denying those coming after the benefit of the GP's professional opinion. (4) That such an extremely psychiatrically unwell patient does not have the benefit of assessment from a health care professional qualified to make recommendations for section at first instance, despite explicit referral for the same from the doctor who knows him best. (5) That secondary care services both the HTT and Liaison Psychiatry appear under to be under-resourced especially in terms of medically qualified personnel, and that this apparent under-resource impacts on the ability of these services to make accurate assessments of patients. (6) That The SUI report missed all matters in issue in this case.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. **It is for each person or organisation to whom or which this report is addressed to identify and respond to the matters pertinent to their area of work.**
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 11th June 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 following Interested Person :  I have also sent it to the following persons or organisations who may find it useful or of interest: Bridge Lane Group Practice, 20 Bridge Lane, London. SW11 3AD.

Consultant Psychiatrist,
Ward 2,
Wandsworth Recovery Team,
Springfield University Hospital,
London.
SW17 7DJ.

Consultant Psychiatrist,
Wandsworth Crisis and Home Treatment Team,
Springfield Hospital,
London.
SW17 7DJ.

Organisations:

1. **Care Quality Commission,**
   Legal Services,
   Citygate,
   Gallowgate,
   Newcastle-upon-Tyne.
   NE1 4PA.

2. **Director of Mental Health Commissioning,**
   NHS England,
   PO Box 16738,
   Redditch,
   B97 9PT.

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 **15th April 2014**

Dr Fiona Wilcox,
HM Senior Coroner,
Inner West London,
Westminster Coroner's Court,
65, Horseferry Road,
London.
SW1P 2ED.