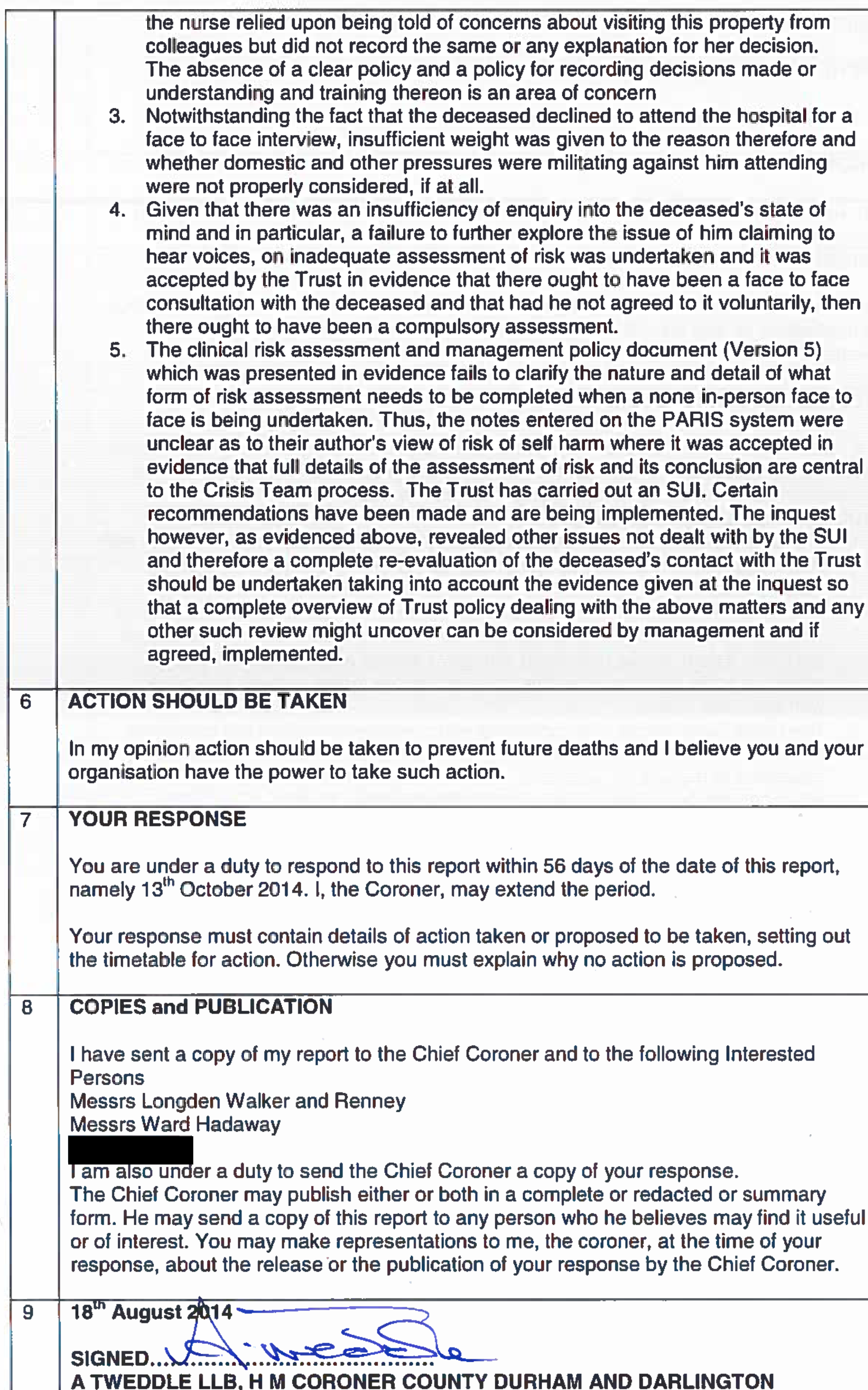
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, Tees, Esk and Wear Valley NHS Trust**
1	**CORONER** I am Andrew Tweddle , Senior Coroner, for the Coroner area of County Durham and Darlington
2	**CORONER'S 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. (see attached sheet)
3	**INVESTIGATION and INQUEST** On 3rd October 2014 I commenced an investigation into the death of Jeffrey Gash aged 46 yrs. The investigation concluded at the end of the inquest on 5th August 2014. The conclusion of the inquest was "intentionally took his own life"
4	**CIRCUMSTANCES OF THE DEATH** 1. The deceased, following a referral from his GP, met with the Crisis Team on 29th August 2013. He was subsequently seen by his GP again and a Consultant Psychiatrist. 2. On 27th September 2014 the GP received a telephone call from the deceased's wife saying that he was distressed and was hearing voices. The GP contacted the Crisis Team, spoke to a nurse who gave advice which resulted in the GP making a home visit to assess the situation before further contact was made with the Crisis Team. 3. The Crisis Team nurse, after speaking with colleagues decided not to make a home visit because of personal safety risks and spoke with the deceased on the telephone to discuss his problems, invite him to attend West Park Hospital and when he declined, gave further contact information to assist. 4. On 28th September, the same Crisis Team nurse received a further telephone call from the deceased stating that he was feeling worse, had spoken to the Samaritans but in evidence, the nurse believed this was a positive not a negative position, as he was seeking assistance, sharing his concerns and she decided not to consider taking matters further not requesting a face to face visit or escalating the matter further. 5. The deceased hung himself on 30th September 2013. 6. The deceased left a note and in this he said " You no I went to see the doctors at West Park Hospital I was hurting every day but they weren't interested".
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] 1. The Crisis Team nurse accepted in evidence that she had not been as forceful as she could and should have been to explore with the deceased his new symptoms, auditory hallucinations, hearing voices. This evidences a lack of training and understanding of the nature of and importance of an appropriate level of telephone assessment 2. No evidence was provided at the inquest to indicate a formal Trust policy on when to decline home visits on the grounds of personal safety and security and



	the nurse relied upon being told of concerns about visiting this property from colleagues but did not record the same or any explanation for her decision. The absence of a clear policy and a policy for recording decisions made or understanding and training thereon is an area of concern 3. Notwithstanding the fact that the deceased declined to attend the hospital for a face to face interview, insufficient weight was given to the reason therefore and whether domestic and other pressures were militating against him attending were not properly considered, if at all. 4. Given that there was an insufficiency of enquiry into the deceased's state of mind and in particular, a failure to further explore the issue of him claiming to hear voices, on inadequate assessment of risk was undertaken and it was accepted by the Trust in evidence that there ought to have been a face to face consultation with the deceased and that had he not agreed to it voluntarily, then there ought to have been a compulsory assessment. 5. The clinical risk assessment and management policy document (Version 5) which was presented in evidence fails to clarify the nature and detail of what form of risk assessment needs to be completed when a none in-person face to face is being undertaken. Thus, the notes entered on the PARIS system were unclear as to their author's view of risk of self harm where it was accepted in evidence that full details of the assessment of risk and its conclusion are central to the Crisis Team process. The Trust has carried out an SUI. Certain recommendations have been made and are being implemented. The inquest however, as evidenced above, revealed other issues not dealt with by the SUI and therefore a complete re-evaluation of the deceased's contact with the Trust should be undertaken taking into account the evidence given at the inquest so that a complete overview of Trust policy dealing with the above matters and any other such review might uncover can be considered by management and if agreed, implemented.
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 13th October 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 Persons Messrs Longden Walker and Renney Messrs Ward Hadaway 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	**18th August 2014** **SIGNED..** **A TWEDDLE LLB, H M CORONER COUNTY DURHAM AND DARLINGTON**

SCHEDULE 5 paragraph 7

ACTION TO PREVENT OTHER DEATHS

1)Where—

(a)a senior coroner has been conducting an investigation under this Part into a person's death,

(b)anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and

(c)in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,

the coroner must report the matter to a person who the coroner believes may have power to take such action.

(2)A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it.

(3)A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner.

Regulations 28 and 29

Report on action to prevent other deaths

28.—(1) This regulation applies where a coroner is under a duty under paragraph 7(1) of Schedule 5 to make a report to prevent other deaths.
(2) In this regulation, a reference to "a report" means a report to prevent other deaths made by the coroner.
(3) A report may not be made until the coroner has considered all the documents, evidence and information that in the opinion of the coroner are relevant to the investigation.
(4) The coroner—
(a) must send a copy of the report to the Chief Coroner and every interested person who in the coroner's opinion should receive it;
(b) must send a copy of the report to the appropriate Local Safeguarding Children Board (which has the same meaning as in regulation 24(3)) where the coroner believes the deceased was under the age of 18; and
(c) may send a copy of the report to any other person who the coroner believes may find it useful or of interest.
(5) On receipt of a report the Chief Coroner may—
(a) publish a copy of the report, or a summary of it, in such manner as the Chief Coroner thinks fit; and
(b) send a copy of the report to any person who the Chief Coroner believes may find it useful or of interest.

Response to a report on action to prevent other deaths

29.—(1) This regulation applies where a person is under a duty to give a response to a report to prevent other deaths made in accordance with paragraph 7(1) of Schedule 5.
(2) In this regulation, a reference to "a report" means a report to prevent other deaths made by the coroner.

(3) The response to a report must contain—
(a) details of any action that has been taken or which it is proposed will be taken by the person giving the response or any other person whether in response to the report or otherwise and set out a timetable of the action taken or proposed to be taken; or
(b) an explanation as to why no action is proposed.
(4) The response must be provided to the coroner who made the report within 56 days of the date on which the report is sent.
(5) The coroner who made the report may extend the period referred to in paragraph (4) (even if an application for extension is made after the time for compliance has expired).
(6) On receipt of a response to a report the coroner—
(a) must send a copy of the response to the report to the Chief Coroner;
(b) must send a copy to any interested persons who in the coroner's opinion should receive it; and
(c) may send a copy of the response to any other person who the coroner believes may find it useful or of interest.
(7) On receipt of a copy under paragraph (6)(a) the Chief Coroner may—
(a) publish a copy of the response, or a summary of it, in such manner as the Chief Coroner thinks fit; and (b) send a copy of the response to any person who the Chief Coroner believes may find it
useful or of interest (other than a person who has been sent a copy of the response under paragraph (6)(b) or (c)).
(8) A person giving a response to a report may make written representations to the coroner about—
(a) the release of the response; or
(b) the publication of the response.
(9) Representations under paragraph (8) must be made to the coroner no later than the time when the response to the report to prevent other deaths is provided to the coroner under paragraph (4).
(10) The coroner must pass any representations made under paragraph (8) to the Chief Coroner who may then consider those representations and decide whether there should be any restrictions on the release or publication of the response.