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:** [redacted] **Strategic Services Manager, Care Governance, Adult Services,** **Hampshire County Council,** **The Castle,** **Winchester** **SO23 8UQ**
1	**CORONER** I am David Clark Horsley, Senior Coroner, for the Coroner area of Portsmouth and South East Hampshire
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 18th September 2013 I commenced an investigation into the death of Tessa Karen Elizabeth Summers, Aged 20. The investigation concluded at the end of the inquest on 3rd July 2014. The conclusion of the inquest was: Medical Cause of Death: 1a. Morphine Toxicity Coroner's Conclusion as to the Death: Death due to an Accident
4	**CIRCUMSTANCES OF THE DEATH** 1 At about 10.00 hours on 9th September 2013 Tessa Karen Elizabeth SUMMERS was found in bed in a collapsed state. An ambulance was called and paramedics attempted to resuscitate her en route to Queen Alexandra Hospital. Resuscitation continued after arrival at the hospital but was unsuccessful and she was pronounced deceased at 11.18 hours on that day. 2. Tessa, who had complex emotional problems, had taken an overdose of her medication as a kind of gesture. She had previously behaved in a similar way but had obtained help before her life was endangered. From the evidence I heard, I believe it was Tessa's intention when she took the overdose that she would seek medical help later the next day.

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. I heard in evidence that the social workers who decided on amendments to Tessa's risk assessment did not record in that document their rationale for downgrading her from high to low risk of self-harm and allowing her to have access to her medication which she could then take without supervision by her Shared Lives Carer. I was told the social workers were not required to do so as a matter of routine to record why details of risk assessments for any of the clients were being changed. 2. I gained the impression from some of the Inquest witnesses that Adult Social Services could beneficially provide more training and support for Shared Lives Carers where the carers would be called upon to work with clients with mental health and emotional problems.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths by addressing my concerns 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 17th 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: Members of Tessa Summer's family. 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	**22nd August 2014** **David Clark Horsley, Ll.B, Solicitor: HM Senior Coroner, Portsmouth and South East Hampshire**