VERONICA HAMILTON-DEELEY, LL.B.
Her Majesty's Senior Coroner
for the City of Brighton & Hove

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CORONERS SOCIETY OF ENGLAND AND WALES

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], Chief Executive, Sussex Partnership Trust** **2. [redacted] – Chair Community Governance** **3. [redacted] Service Director, Brighton & Hove City Council**
1	**CORONER** I am **Veronica HAMILTON-DEELEY,** Senior Coroner, for the City of Brighton and Hove
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 **4th August 2014** I commenced an investigation into the death of **Paul Leslie HYDE**. The investigation concluded at the end of the inquest on **12th November 2014**.The conclusion of the inquest was **MISADVENTURE**
4	**CIRCUMSTANCES OF THE DEATH** **See Record of Inquest**
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) On the 14th April 2014, GP Dr. Peter Devlin having anxieties expressed to him by one of the Community Mental Health Workers concerning Paul Hyde's deteriorating condition, sought advice from the Assessment and Treatment Team of the Community Mental Health Services. He spoke to Graham Walton who advised him that he should refer Mr. Hyde back to ATS (Assessment and Treatment Service). He therefore wrote a letter on the 15th July, 2014 and this

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	was sent so that it arrived on the same day, expressing his anxiety. (2) The request was for Mr. Hyde to see a Psychiatrist to carry out a medication review. It is clear that this Medication Review needs to be carried out by the Psychiatrist in a face-to-face review with the patient. (3) The referral was not appropriately addressed until some 14 days in to the 28-day period within which the patient is required either to have been seen by ATS or the Psychiatrist or the GP. It was decided, though very poorly documented that the Psychiatrist should phone the GP to see whether, after discussion, it was possible for the GP to prescribe a new medication for Mr. Hyde. It should have been obvious from the start that this was not a direction for this referral to take. There seems to be no facility for the Psychiatrist to be involved in the assessment procedure and indicate a course him or herself. There should be. In any event, no contact was made with the GP and there is apparently no follow up system so no one seems to have picked up that not only was Mr. Hyde not seen within the 28-days of referral, but in fact that he was not seen at all i.e. he was lost to follow up. (4) From the point of view of Mr. Hyde, the re-referral system was not fit for purpose. In the event, Mr. Hyde took an overdose of the medication which had been stopped, although he still had some tablets, and the very sedatory effect that he had complained about kicked in, resulting in his death.
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 (**5th December 2014**), namely by **24th February 2015**. I, Veronica Hamilton-Deeley, 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 1. Clinical Commissioning Group 2. [redacted] (Mother) 3. [redacted] (Father) 4. Secretary of State for Health, Department of Health 5. Sir David Nicholson/Simon Stevens – Chief Executive NHS England 6. National Patient Safety Agency

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	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: 5th December 2014** **SIGNED BY:** V Hamilton Deeley **Veronica HAMILTON-DEELEY** **Senior Coroner Brighton and Hove**