REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Devon Clinical Commissioning Group** 2. **NHS England**
1	**CORONER** I am Lydia Brown assistant coroner, for the coroner area of County of Devon (Exeter and Devon Greater District)
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 26th August 2013 I commenced an investigation into the death of George Christian Werb aged 15. The investigation concluded at the end of the inquest on 8th October 2014. The conclusion of the inquest was a Narrative Verdict : George died on 28 June 2013 on the railway track at Seaton Station, Seaton, Devon. At that time he was on home leave from inpatient care in a child psychiatric unit. Before he went on leave he was assessed as having no suicidal risk but the information used in this assessment was incomplete inaccurate and did not reflect the actual situation. Poor engagement with the family, placing him in a unit a long distance from home, absent note keeping and inadequate internal communications all contributed to this outcome.
4	**CIRCUMSTANCES OF THE DEATH** George Christian Werb was receiving treatment for serious Mental Health issues, including a probable diagnosis of psychosis and depression, and was detained under Section 3 of the Mental Health Act and admitted to the Priory Hospital, Southampton 23 May 2014 for treatment. This was the nearest unit available for a child with George's needs, notwithstanding this was more than a 2 hour drive away from the home address, and friend and family support. George continued to receive treatment for a number of weeks, then the Section was lifted, and periods of home leave were commenced. The second of these periods of home leave commenced on 27th June 2014, notwithstanding that the situation had not been effectively risk assessed. Communication with the family was poor and due to the distance between the treating hospital and home address. No family therapy had been undertaken and the family had not received appropriate and full information of their son's diagnosis and the risk of suicide had not been adequately considered before leave was allowed. George walked onto a railway track near his home the morning after his home leave commenced and died when he was hit by an express train.

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) The community team had to spend much time making numerous telephone calls to locate a child psychiatric bed. There was not at the time, and still appears to be no, or no effective bed bureau system to identify spaces. This is wasteful of clinician time, creates inevitable delays and is indicative that there are routinely too few available beds to serve the needs of our child psychiatric patients. (2) On a previous admission during May 2014 the bed located was in Huntercombe, and George was removed by his father as the bedroom had inadequate furniture, had no bed linen and there was concern the environment was adding to George's distress. The distance between home and this placement was in excess of 3 hours travel time. (3) On the index admission, George was placed in the Priory Hospital, Southampton, a distance of over 2 hours travelling time from home. This is not an NHS facility and is specifically for "overflow" patients from all across England, many of whom are therefore huge distances from their home, their family, their friends and community support. (4) Due to the distance, the hospital made the decision that family therapy could not take place (although the parents would have engaged if the importance of this was explained) and periods of home leave were extended due to travelling times, rather than in response to clinical need. (5) There was poor attendance at the CPA meeting, and both parents and the community team only "attended" by telephone, which was far from ideal and impacted on the effectiveness of communication between all parties. (6) Having local accessibility where in patient care is required was recognized in the Mental Health Crisis Care Concordat published 18 February 2014 to be important to keep the young person close to home, school and friends and this was also recognized by all the clinicians at inquest to be important and necessary. With current provision of beds this need is not being met, and is impacting on patient care. (7) In this case I consider the distance of the unit directly contributed to the circumstances that led to George's death.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organization has 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 23rd December 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, [redacted] and to the LOCAL SAFEGUARDING BOARD as George was under 18. I have also sent it to Norman Lamb, Minister of State, Department of Health [redacted]GMC who may find it useful or of interest. 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	**19 November 2014**	**Signed** ..... **Lydia Charlotte Brown** **HM Assistant Coroner** **Room 226** **County Hall** **Topsham Road** **EXETER** **Devon** **EX2 4QD**