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. Mr S Wilson, Kernow Clinical Commissioning Group, The Sedgemoor Centre, Priory Road, St Austell, Cornwall, PL25 5AS 2. Mr J Hunt, Secretary of State for Health, Department of Health, Richmond House, 79 Whitehall, London, SW1A 2NS
1	**CORONER** I am Andrew Cox, Assistant Coroner for Cornwall, The New Lodge, Newquay Road, Penmount, Truro, Cornwall, TR4 9AA
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 2 October 2012 I commenced an investigation into the death of Shannon Kimberley Gee aged 16 years. The investigation concluded at the end of a four day inquest on 29 January 2015. I made a determination that Shannon died as the result of an Accident.
4	**CIRCUMSTANCES OF THE DEATH** Shannon was recognised as a Child in Need. Intervention by Social Care had been considered but instead her case was referred to the Children and Adolescents Mental Health Team (CAMHT.) It was identified that a large part of Shannon's difficulties related to the fact that both her parents suffered from mental health issues. For the purposes of this letter it is the position of Mrs Gee that is relevant. [redacted]

	[redacted] The inquest heard from [redacted] currently the Acting Clinical Lead for OSW. A copy of her statement is enclosed and your attention is drawn to paragraph one on page two. Of note: - Due to the non-receipt of notes and records that had been requested in other cases OSW no longer routinely requested such information from CMHT; - There was a gap in the provision of mental health services in that [redacted] (and others) were deemed too ill for OSW yet too well for CMHT. This resulted in a stand-off and the patient not being treated as a consequence. It is right to acknowledge that the two organisations have recognised the less than desirable state of affairs. At inquest I was told that since October 2014 a four-stage process has been put in place for determining any such clinical disputes with decision-making ultimately lying with the Kernow Clinical Commissioning Group. Another witness, [redacted] (no relation) told me she had experience of patients who had been through the process which she said had taken 'weeks' to resolve.
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. – The situation now is improved from when [redacted] encountered the delay in treatment to her but, on the evidence of [redacted] a delay of 'weeks' in resolving clinical disputes as to which organisation should treat a patient is still worrying. Ideally, there should be a seamless union between the two organisations. The fact that there is not appears to be a consequence of the maximum threshold for treatment by OSW being lower than the minimum threshold for acceptance on to the CMHT workload. Put another way, it is entirely conceivable that both OSW and CMHT may be correct in applying their respective rules as to whether a patient needs to be taken on where that patient's presenting complaints falls between the two organisations' rules. That may require formal guidance to resolve hence directing this letter to the Secretary in addition to the Commissioners. The difficulties set out concerning the transfer of medical notes and records appear more difficult to justify.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 Tuesday, 31 March 2015 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 following. HHJ Peter Thornton QC, the Chief Coroner of England & Wales, family of Shannon Gee, [redacted] OSW, [redacted] (CPFT) Local Safeguarding Children Board. I am also under a duty to send the Chief Coroner a copy of your response. 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	**3rd February 2015** **Andrew Cox**