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. Mrs J Youart, Managing Director, Kernow Clinical Commissioning Group, 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 the coroner area of Cornwall, New Lodge, Newquay Road, Penmount, TRURO, 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 12 July 2013 I commenced an investigation into the death of George Allan Taylor aged 80. The investigation concluded at the end of a two day jury inquest on 3 February 2015. The jury made a determination that Mr Taylor committed suicide.
4	**CIRCUMSTANCES OF THE DEATH** Mr Taylor had a past medical history that included mental health issues. On 25 July 2012 he took an overdose of medication and subsequently spent 7/8 months as an inpatient at Longreach Psychiatric Hospital in Camborne/Redruth, Cornwall. He was discharged in March 2013. On 24 June 2013 Mr Taylor took a second overdose of medication. He was described as despondent and having feelings of hopelessness at the time. This was believed to be related to the fact that his wife, who was everything to him, suffered from dementia and no longer recognised him. Mr Taylor was assessed in Royal Cornwall Hospital Truro in Cornwall. It was felt that an informal admission into hospital may be appropriate. Mr Taylor agreed with this. An acute psychiatric hospital bed was not immediately available. The next day Mr Taylor's treatment plan changed and it was felt appropriate that he could be managed in an Interim Assessment And Treatment Bed in a care home. He also developed norovirus and needed to remain in hospital for a few days. An acute psychiatric bed did become available but the consultant treating Mr Taylor no longer felt that this was needed. When an acute psychiatric bed was not immediately available consideration was given to sending Mr Taylor to an out of county bed. This was notwithstanding the fact that it

	was recognised one of the features of his previous suicide attempts was his social isolation On 28 June 2013 Mr Taylor moved to The Brake Manor care home near St Austell. On 30 June Mr Taylor said he wanted to return home. On 1 July Mr Taylor was seen by the Home Treatment Team and his Care Co-ordinator who was a Community Mental Health Nurse. Mr Taylor was adamant that he would not remain in the care home. A team decision was reached that Mr Taylor remained at high risk of deliberate self-harm. It was felt, however, that Mr Taylor had capacity and there were no grounds for seeking his informal admission into hospital or convening a Mental Health Act assessment. It was agreed that Mr Taylor could return home under the daily supervision of the Home Treatment Team. On 2 July the Home Treatment Team attempted to contact Mr Taylor at home but he was found hanged. During the evidence I heard from [redacted] who is an Associate Director at Cornwall Partnership Foundation Trust responsible for inpatient care. She said that, in recent years, there has been an increase in demand for acute psychiatric beds (in keeping with the national picture) but no additional allocation of beds has been provided. This has resulted in 8 to 12 patients per month typically having to go out of county for treatment. She was of the view that there was an inadequate provision of acute psychiatric beds in Cornwall. The inquest also heard from [redacted] from Kernow Clinical Commissioning Group. She advised that for the year 2013/14 the cost of treating Cornish acute psychiatric patients out of county was £1.4 million. [redacted] also stated in evidence that resourcing for the Home Treatment Team, the gatekeepers for acute psychiatric beds, fell below nationally benchmarked standards. [redacted] told the inquest that a review between Cornwall Partnership Foundation Trust and Kernow Clinical Commissioning Group is currently underway looking at all services and the allocation of resources.
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. – It was established in evidence that Mr Taylor's death was not caused by the lack of an acute psychiatric bed. Furthermore, it was established that no patient had died out of county because an in county acute psychiatric bed was not available. It was further established that no patient had died in Cornwall while waiting for an acute psychiatric bed to become available That said, it appears far from desirable that 8 to 12 patients are being sent out of county per month due to a lack of acute psychiatric beds. It is easy to see that, with only a small change in circumstances, a future death could result as a consequence of a lack of acute psychiatric beds.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 Friday 3 April 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: His Honour Judge, Peter Thornton QC, the Chief Coroner of England & Wales, the family of Mr Taylor and Cornwall Partnership Foundation Trust, an interested person at the inquest proceedings. 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	**6th February 2015** **Andrew J Cox**