IAN SINGLETON
Assistant Coroner for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Right Honourable Jeremy Hunt MP, Secretary of State for Health** **Mr Duncan Selbie, Chief Executive, Public Health England** **Right Honourable Anna Soubry MP, Minister of State for Defence Personnel, Welfare and Veterans** **Mr Iain Tulley, Chief Executive, Avon & Wiltshire NHS Mental Health Partnership Trust** **Mr Peter Hill, Chief Executive, Salisbury Hospital NHS Trust** **Ms Nerissa Vaughan, Chief Executive, The Great Western Hospital NHS Trust**
1	**CORONER** I am IAN SINGLETON, Assistant Coroner for Wiltshire and Swindon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 29/10/2012 I commenced an investigation into the death of Richard Jeffrey Jones aged 23. The investigation concluded at the end of the inquest on 27 January 2015, having heard evidence on 11 July 2013, 13, 14 and 15 January 2015. The conclusion of the inquest was a Narrative one.
4	**CIRCUMSTANCES OF THE DEATH** Richard was at home on his own and during the period 14 to 15 October 2012 voluntarily ingested such a quantity of tramadol that on a balance of probabilities it lead to a loss of consciousness and respiratory depression leading to aspiration of the gastric contents which caused his death. The reason as to why Richard had taken the medication and his intentions in doing so were unclear.
5	**CORONER'S CONCERNS** During the course of the Inquest I had cause to hear evidence from a number of witnesses involved in the care of Richard, a serving member of the Armed Forces, when he complained of auditory hallucinations, persecutory delusions, low mood, disrupted sleep and poor concentration. I should make it clear that during the Inquest I did not hear any evidence which indicated that it would have been appropriate for Richard to have been detained against his will or that the lack of being detained caused or contributed to his death. Notwithstanding the above, if evidence is presented to a Coroner as part of an Inquest process irrespective of it being unconnected with the circumstances of that person's death , a Coroner

	can make a Regulation 28 report if he or she has concerns with a view to the prevention of future deaths. The witnesses included those employed by Avon & Wiltshire NHS Mental Health Partnership, the Defence Mental Health Service and Salisbury Hospital NHS Trust with whom Richard had come into contact when seeking help for his mental health issues particularly during the period 12-13 October 2012. It was acknowledged by the witnesses from the Salisbury Hospital NHS Trust that Richard needed to be assessed by an experienced mental health practitioner with a degree of urgency. An assessment had been due to be carried out shortly after 10 am on the 13 October 2012, but Richard left before it could take place. Avon & Wiltshire Mental Health NHS Partnership Trust in evidence accepted that they took over responsibility for Richard's care following a call from the Hospital to advise that Richard had left. There was contradictory evidence as to whether the appointment had been cancelled or changed to a requirement for a home visit and as to the degree of urgency. A referral was made by Avon & Wiltshire NHS Mental Health Partnership to the Defence Community Mental Health Service who were only said to provide an advisory service out of hours and not to be responsible for direct contact with patients. Richard was telephoned at home by a member of the Defence Community Mental Health Service a mental health nurse with 20 years experience There was contradictory evidence as to what was said during the telephone conversation between AWP and the Defence Community Health Service as to whether it was only an advisory service with no ability to carry out assessments, the degree of urgency and the level of risk. The reason for writing to each of you is that I understand you have some degree of control with regard to the provision of care for members of the armed forces who appear to be suffering from mental health issues. I am concerned in particular as to the following matters : a) As to the way in which information obtained from such a patient is recorded , with especial reference to the perceived level of risk and the degree of urgency in carrying out an assessment. b) As to how that information is shared with other agencies involved in the care of that patient to ensure that it is accurately passed on, particularly as to the level of risk and degree of urgency. c) As to who has primary responsibility for the care of that patient and how that is recorded by all those involved, particularly where there is a transfer of care. I would ask you to review the policy and procedures that you have in place to deal with the referral to another agency of a member of the armed forces who appears to be suffering from mental health issues having regard to the above concerns.
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 20 April 2015. I, the Assistant 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] [redacted] Royal British Legion [redacted] Defence Inquest Unit [redacted] Salisbury District Hospital NHS Trust [redacted] Avon & Wiltshire NHS Mental Health Partnership Trust 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	Dated 20 February 2015 Signature [redacted] Assistant Coroner for Wiltshire and Swindon