	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr Neil Carr OBE, Chief Executive, South Staffordshire and Shropshire NHS Foundation Trust**
1	**CORONER** I am Mr Andrew Haigh senior coroner for the coroner area of Staffordshire South
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 3 December 2013 I commenced an investigation into the death of Peter Jonathan Wright aged 49 years. The investigation concluded at the end of the inquest on 26 February 2015. The conclusion of the inquest was 'suicide while suffering severe depression and psychosis'.
4	**CIRCUMSTANCES OF THE DEATH** Mr Wright was certified dead at 22.40 hours on 29 November 2013 at St George's Hospital in Stafford. He had been a voluntary patient there and had deliberately cut an artery in his neck using a broken metal fork. He had been observed by staff shortly prior to the incident but because of work pressure on staff the observations had not been recorded. No doctor from the hospital was available to attend the scene.
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) At the time of the death the ward was understaffed. Of the quota staff of three, one care assistant had been called to assist in another ward (and had in fact just returned) and one care assistant was with another patient who required continuous observation. This left just the qualified nurse to deal with 16 patients. She did not record all necessary observations and was doing a drugs round by herself (contrary to policy). This was recognised in the SIR carried out by [redacted] but no recommendation was made about it on the basis that the Trust was undergoing a major staffing review in any event. It may therefore be that the situation has already been addressed but this was not clear to me at

	the Inquest and the impression I received from the nurse was that there is now some extra support at times but it is still not satisfactory. (2) At the time of this incident there was still a 24 hour Emergency Department at the nearby Stafford Hospital and at St George's Hospital there was no doctor on site. Now the Emergency Department at County (formerly Stafford) Hospital is not open during the night and the nearest ED is at Stoke. I was told that the situation can be managed by calling paramedics. While I appreciate that nearly all the doctors at St George's are psychiatrists not medics I wonder if any consideration has been given to out of hours cover by a doctor?
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, namely by 27 April. 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] widow of the deceased Osborne Morris and Morgan solicitors for the family Weightmans solicitors for the Trust 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	**2 March 2015** [redacted] Andrew A Haigh HM Senior Coroner Staffordshire (South)