Nicola Jane Mundy
Senior Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive** Rotherham Doncaster And South Humber Woodfield House Trust Headquarters, Tickhill Road Hospital Doncaster DN4 8QN
1	**CORONER** I am Nicola Jane Mundy, Senior Coroner for South Yorkshire (East 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. 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 06/12/2013 I commenced an investigation into the death of James Savo, aged 27. The investigation concluded at the end of the inquest on 01 June 2015. The conclusion of the inquest was a Narrative Conclusion Mr Savo's cause of death was 1a Hanging and the Narrative Conclusion is as follows "James Savo had a long standing history of depression. Following his first period of inpatient treatment he was discharged home on 29 November 2013. At the time of his discharge insufficient weight was attached to both the timing and nature of the home treatment team's input and also to family concerns and issues. On balance this led to earlier discharge that should have been the case. Mr Savo hanged himself in woodland off Scholes Lane on 3rd December 2013. Had Mr Savo not been discharged on 29 November 2013 it is unlikely that he would have died at the time he did.
4	**CIRCUMSTANCES OF THE DEATH** Mr Savo had a long standing history of depression. In October 2013 he had his first period of inpatient treatment. During that time there was a change in his anti-depressant, assessment on the ward and four periods of home leave, three of which were with his family the fourth period and, longest, was with a friend. There was insufficient communication with the family regarding Mr Savo's presentation and their views on home leave. The last direct Home Treatment Team involvement was some 9 days prior to discharge when there was still issues with Mr Savo's home environment, family tensions. There was a need for on-going assessment of his response to medication. He had continuing suicidal thoughts. There was noted to be improvement in the ward setting although he was not as well whilst at home. After a seven day period of leave with a friend Mr Savo returned to the ward where he was then discharged back to his home environment; a Home Treatment Team representative - was not present at this meeting. Their last involvement would have been documented in the computerised records, with the last assessment being some 9 days prior to discharge. There was no evidence of communication with the family/carers at this time. Following Mr Savo's discharge there was a crisis situation 2 days later where the decision was made to continue James' treatment in the community setting (whilst he remained at home). 4 days after discharge on the 3rd December Mr Savo hanged himself.
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 systems described as being in place which should be followed to ensure effective communication between families/carers appear not to be routinely followed. As this communication is an integral part of a patient's management and future treatment plans it is essential that all staff are aware of the need for this communication, the nature of it and who has primary responsibility for ensuring that it takes place. Furthermore, there is no evidence of any effective auditing process to ensure such systems are being followed. (2) The early discharge plan was described as a mechanism to try and ensure a seamless transition from inpatient care to community based care in appropriate cases. Whilst this is clearly a system adopted locally and currently being re-evaluated, given it's significance in facilitating smooth transitions at a time which was recognised as being difficult for many patients returning to the community, consideration should be given as to whether the current guidance etc adequately incorporates the ethos and workings of the early discharge plan. Witnesses knowledge and understanding of this pathway was variable.

Coroner's Court and Office, Doncaster Crown Court, College Road, Doncaster, DN1 3HS
Tel 01302 320844 | Fax 01302 364833

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you The Chief Executive and Medical Director 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 July 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 Chief Coroner and to the following Interested Persons [redacted]. I have also sent it to 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	Dated 01 Jur[redacted] Signature___ Senior Coron[redacted]istrict)