IAN SINGLETON
Assistant Coroner for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **James Scott, Chief Executive, Royal United Hospitals Bath NHS Foundation Trust, Combe Park, Bath, BA1 3NG** **Iain Tulley, Chief Executive, Avon & Wiltshire NHS Mental Health Partnership Trust, Trust Headquarters, Jenner House, Langley Park, Chippenham, Wiltshire SN15 1GG** **[REDACTED] Corporate Director, Wiltshire Council, Wiltshire Allied Mental Health Professional Service, County Hall, By the Sea Road, Trowbridge, Wiltshire BA14**
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 05 February 2013 an investigation was commenced into the death of Elizabeth Godwin aged 48. The investigation concluded at the end of the Inquest on the 19 May 2015, having heard evidence on the 7 and 8 April as well as the 19 May 2015. The conclusion was one of suicide whilst suffering from anxiety and depression.
4	**CIRCUMSTANCES OF THE DEATH** Elizabeth ("Liz") was left alone at home for a brief period on the 28 January 2013 and whilst in the bathroom attached one end of a ligature made from a dog lead to the bar of the shower cubicle before hanging herself.
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 Liz a farmer's wife, who had a long history of anxiety and depression particularly during the winter months which had been dealt with by medication prescribed by her GP. The witnesses included those employed by Avon & Wiltshire NHS Mental Health Partnership Trust, Royal United Hospital, Wiltshire Council Mental Health Team, the Out Of Hours Duty Service and the GP. Although I had concerns about the way in which the various agencies involved with Liz, communicated, there was insufficient evidence on a balance of probabilities to say that but for those concerns Liz would not have died. Where evidence is presented to a Coroner as part of an Inquest process, irrespective of whether it is connected with the circumstances of that persons death, a Coroner can make a Regulation 28 Report if

he or she has concerns with a view to the prevention of future deaths.

In 2009 the symptoms had persisted beyond the Winter and in January 2010 Liz had taken an overdose and was referred to the Primary Care Psychiatric Liaison Team. Liz had appeared to improve over the next few years but in January 2013 had informed her GP that she was becoming stressed. Her medication was reviewed and increased.

Liz had difficulty sleeping and found it difficult to cope when she became anxious during the night.

On the 18 January 2013 Liz took an overdose of a horse sedative in an attempt to get some sleep. She was admitted to the Royal United Hospital in Bath. A mental health assessment matrix was completed which scored a yellow, not a high risk. I found that the opportunity to gather information from Liz's husband was missed and Liz was allowed home after 6 hours observation.

On the 20 January 2013 whilst at home, Liz was observed with her hands around her throat, trying to strangle herself. Fearful for Liz 's safety and well being, a call was made to the Out Of Hours Emergency Duty Service. A GP attended who found Liz to be deeply distressed wanting to take her own life but unwilling to accept a voluntary admission to a psychiatric unit.

A request was made by the GP for arrangements to be made for Liz to be admitted under Section to a psychiatric hospital that evening , as he believed there was a real and immediate risk of her taking her own life.

Arrangements were made for a bed on a psychiatric unit to be available together with transportation, once the Sectioning had taken place. The on call psychiatrist was unable to attend and Liz then fell asleep. The decision was taken to delay the assessment until the following day, 21 January 2013.

Liz saw a GP on the 21 January 2013 who was of the view that a formal mental health assessment was not required but that Liz would need some form of mental health input. After the consultation with Liz, the GP spoke to the Approved Mental Health Practitioner from Wiltshire Council's Mental Health Team who was the duty AMHP that day, responsible for gathering information and deciding if a Mental Health Assessment was still required and if so to carry it out.

The AMHP, taking account of the views of the GP who had seen Liz that morning and the fact that Liz had not been detained or referred for an assessment, following her admission to the Royal United Hospital, decided that there was no need for a Mental Health Act assessment.

The AMHP assumed that Liz would be supported and or assessed by either the Intensive Service or Primary Care Liaison on the basis that having decided no Mental Health Act assessment was required she had discharged her duty. The AMHP believed that it would be apparent to the Intensive Service that she was no longer involved in Liz's care given that the bed in the psychiatric unit had been cancelled.

Over the period of 22 to 24 January 2013 Liz's condition fluctuated as she was watched over by her family and close friend. On the 24 January 2013 a telephone call was made to the GP expressing concern about the possibility of Liz self harming. As a result, a letter was sent by the GP to the Community Mental Health Team requesting that a full assessment be carried out at an urgent appointment.

When the details of that request were entered into the electronic record system of Avon and Wiltshire NHS Mental Health Partnership Trust, it was noted that a referral had recently been dealt with by the AMHP, but who was then out of the office.

Arrangements were made for the AMHP to visit Liz the following week and for a telephone call to be made to Liz that day informing her of the position. The person who made the call understood that the reason for it, was to make contact with Liz and to provide a telephone number if she needed help or wanted to talk. In the event Liz could not be contacted and a message was left.

On the 28 January 2013 the duty worker at AWP noted that Liz had not returned her call and notified the manager of the AMHP.

It was unclear why no attempt was made to contact Liz as a matter of urgency on 28 January 2013 other than that the sense of urgency had drifted away.

It was not until late in the day and in fact after Liz's death, that a member of the Primary Care Liaison Team noted that the referral from the 25 January 2013 had not been resolved and having made

	enquiries, allocated it to herself to triage. **I AM CONCERNED IN PARTICULAR AS TO THE FOLLOWING MATTERS :** a) As to the way in which information is gathered from the family and others involved where there is a need for an individual to have a mental health assessment. b) As to how the urgency of carrying out that assessment, is assessed, recorded and monitored. c) As to how that information is shared with other agencies involved in the care of that patient. d) As to who has responsibility for the care of that patient including the carrying out of the mental health assessment and any treatment arising from it. e) As to how a transfer of that care between the agencies is communicated and acknowledged so that there is a clear audit trail. 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 patient 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 14 August 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] Bevan Brittan Solicitors for AWP and RUH 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 Assistant Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	Dated 19 June 2015 Signature ____________ Assistant Coroner for Wiltshire and Swindon