REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive - Sussex Partnership NHS Foundation Trust.**
1	**CORONER** I am Elisabeth Bussey-Jones, Assistant Coroner, for the Coroner's area of West Sussex.
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 the 23rd November 2015 I commenced an investigation into the death of Joanne Michelle French (otherwise known as Joanne Michelle Hay), aged 38 years. The investigation concluded at the end of the inquest on 1st December 2015. The conclusion of the inquest was suicide and the medical cause of death was 1a) hanging. The short form conclusion of suicide was supplemented by a narrative conclusion in the following terms : "*Joanne French made a serious attempt on her life on the 2nd December 2014 by cutting her throat. She was taken to hospital where she was treated for her injury. She was admitted voluntarily to the psychiatric ward at Meadowfield Hospital on 3rd December 2014. She was discharged from that ward on the 11th December 2014. There were communication errors made in the assessment and decision making process for her discharge which related to obtaining views of members of Joanne's family and the accuracy of information recorded as being provided by the family. Had those communication errors not existed, it is likely that Joanne would not*

	have been discharged on the 11th December 2014".
4	**CIRCUMSTANCES OF THE DEATH** 1) Joanne French first went to see her GP concerning depression in September 2014. Her GP prescribed anti-depressants. She had no prior history of depressive illness. 2) On the 2nd November 2014 she suffered a form of breakdown which resulted in her family taking her to A and E at the Royal Sussex County Hospital. She was not admitted to hospital on that occasion but it did mark the start of her engagement with the Crisis Resolution Home Treatment Team. She was seen at home daily by that team, with slightly reduced contact towards the end of the first month. 3) Joanne French was seen on the 1st December 2014 by a psychiatrist with the Crisis Team, who altered her medication as she was not showing the anticipated improvement. 4) Without any obvious warning signs, Joanne made a significant attempt on her life on the 2nd December 2014, cutting her throat and narrowly missing major arteries. She was admitted to the Royal Sussex County Hospital and then to Meadowfield Hospital. It was not necessary for a decision to be made to detain her under the Mental Health Act as Joanne agreed to voluntary admission. 5) Joanne French was discharged from Meadowfield Hospital on the 11th December 2014, which the Psychiatrist making the decision to discharge her described as an 'exceptional course'. The Psychiatrist gave evidence to the effect that he expected the family's views to be canvassed in the discharge assessment and that his decision on supported discharge would be influenced by the family's views. The importance of that aspect of the assessment to the decision maker was not understood or communicated to the nurse carrying out the assessment for discharge. Although the nurse carrying out the assessment

spoke over the telephone to [redacted] (Joanne's husband) at some point during the assessment process, she did not specifically ask his views and the discussion was in the presence of Joanne French. The nurse conducting the assessment was unaware that the psychiatrist who would be making the discharge decision specifically wanted to know the family's views.

6) The psychiatrist believed that before making the discharge decision he had spoken directly to the nurse undertaking the assessment of Joanne for suitability for discharge but that was disputed by the nurse who undertook the assessment. She denied speaking directly to him and said he was not at the ward at the time. The psychiatrist was therefore reliant on the written notes of that assessment.

7) The notes made of the assessment were inaccurate in that they reported views of [redacted] when in fact those were the views of the patient.

8) Joanne's husband and twin sister were taken by surprise with the decision for her early discharge. They were not aware that the person who would make the decision as to discharge wanted their imput. They had no experience of the procedure and did not understand that their views were relevant to the discharge process, the discharge being presented as a foregone decision.

9) [redacted] had made an arrangement to discuss Joanne French's condition with the psychiatrist on the morning of 12th December 2014 but in light of her early discharge, that appointment never took place.

10) In the early hours of the morning on 14th December 2014 Joanne French was found by a passer-by at Southwick Recreational Ground to be hanging by a scarf attached to her neck and a climbing frame. Emergency Services were called and CPR commenced on their arrival. She was unable to be revived and was transferred to Royal Sussex County Hospital where she was formally pronounced to have died.

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) When taking what was described as an 'exceptional course' in deciding to discharge the patient at an early stage, there was lack of clarity and understanding as to what the person making the decision to discharge required to be covered in the discharge assessment process. (2) Factors that the person making the decision for early discharge required to be covered in the assessment process were not brought to the attention of the person who was to carry out that assessment. (3) The assessment notes were not completely clear and accurate in recording the information to be provided to the person making the decision to discharge. (4) Consent permitting, there was no process by which the unqualified family members who would be instrumental in caring for the discharged patient could imput their views and/or information for those making the decision on early discharge and by which they could understand the reasons for discharge.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 4th March 2016. 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] and solicitors representing the Family 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	**DATE : 7th January 2016** **SIGNED :**  pp **Elisabeth Bussey-Jones**