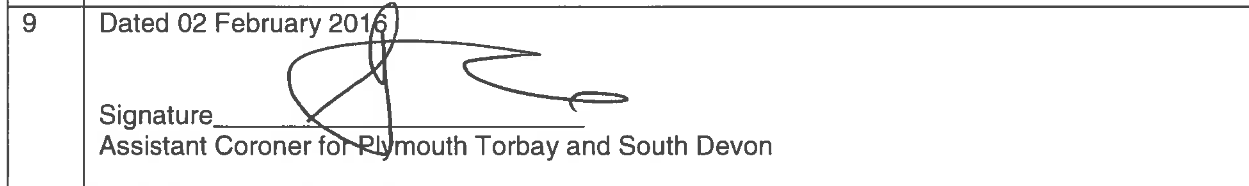
ANDREW JAMES COX
Assistant Coroner for Plymouth Torbay and South Devon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Senior Partner, Knowle House Surgery, 4 Meavy Way, Crownhill, Plymouth**
1	**CORONER** I am ANDREW JAMES COX, Assistant Coroner for Plymouth Torbay and South Devon of 1 Derriford Park, Derriford Business Park, Plymouth PL6 5QZ
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 21 September 2015 I commenced an investigation into the death of Michael John Valentine, 46 years of age. The investigation concluded at the end of an inquest on 2 February 2016. The medical cause of death was recorded as 1 (a) Helium Toxicity and the conclusion was that Mr Valentine had committed Suicide
4	**CIRCUMSTANCES OF THE DEATH** On 17 August 2015 Mr and [redacted] separated. In the early hours of 18 August Mr Valentine posted on line an image of a self-inflicted wound. The Police were notified. Mr Valentine was taken to a place of safety at Derriford Hospital pursuant to Section 136 of the Mental Health Act. He underwent a formal assessment and although distressed and upset was felt not to be suffering from a mental disorder. He was discharged without follow up. On 20 August Mr Valentine was seen by one of the GP's at your Practice, [redacted]. She did not then feel that he was actively suicidal nor did she feel it was necessary to refer him to the mental health team. On 27 August [redacted] spoke again with Mr Valentine who disclosed to her that he was not eating. On 2 September your surgery received a letter from Mr Valentine indicating that he was on hunger strike. [redacted] spoke to him. She also spoke to her colleagues and [redacted] a Consultant Psychiatrist. [redacted] submitted an urgent referral for a mental health assessment. To her knowledge at the time this was not responded to. On 10 September [redacted] spoke to Mr Valentine again. At that point he told her that he had not eaten for 25 days. On 14 September Mr Valentine spoke to one of [redacted]s colleagues. On 16 September Mr Valentine was found deceased.

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) A fax rejecting the request for a mental health assessment was sent back to the Surgery. This was classed as routine and was not brought to the attention of It was left in a tray for dealing (filing) but, unfortunately, due to staff absence, this did not come to light until after the death of Mr Valentine. (2) After the telephone consultation on 10 September, agreed that it would have been appropriate to refer Mr Valentine to the Mental Health Team for a second time given his disclosure that he had not eaten for 25 days. (3) told the Court that there had been a significant events meeting which had looked at the administrative shortcomings in the Surgery. There had been no discussion, however, of her decision not to re-refer following the 10 September telephone contact. Similarly, there has been no discussion of what to do where an application for a mental health assessment has been rejected.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you as Senior Partner of Knowle House Surgery have the power to take such action. While it is a matter for you to reflect upon you may feel that it would be of benefit to audit post that i now received routinely into the Surgery. How long is it before this is reviewed by a doctor? Additionally, you may feel there would be some benefit in arranging a meeting with your colleagues in Secondary Care to discuss the procedure for rejecting urgent mental health act assessments. I have written in similar terms to the Medical Director at Plymouth Community Health Care. At the Inquest indicated that she felt this would be an appropriate step to take. Finally, you may feel that it would be sensible to re-consider the circumstances of Mr Valentine's death in light of the clinical decisions following the telephone contact on 10 September at a significant event meeting. I would be grateful if you would send to me a record of that discussion if you believe it appropriate to hold one.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 29 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 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 02 February 2016  Signature__________________________ Assistant Coroner for Plymouth Torbay and South Devon

3 The Crescent, Plymouth, PL1 3AB
Tel 01752 204 636 | Fax 01752 313297

ANDREW JAMES COX
Assistant Coroner for Plymouth Torbay and South Devon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Medical Director Livewell South West, Mount Gould Hospital, Plymouth
1	**CORONER** I am ANDREW JAMES COX, Assistant Coroner for Plymouth Torbay and South Devon of 1 Derriford Park, Derriford Business Park, Plymouth
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
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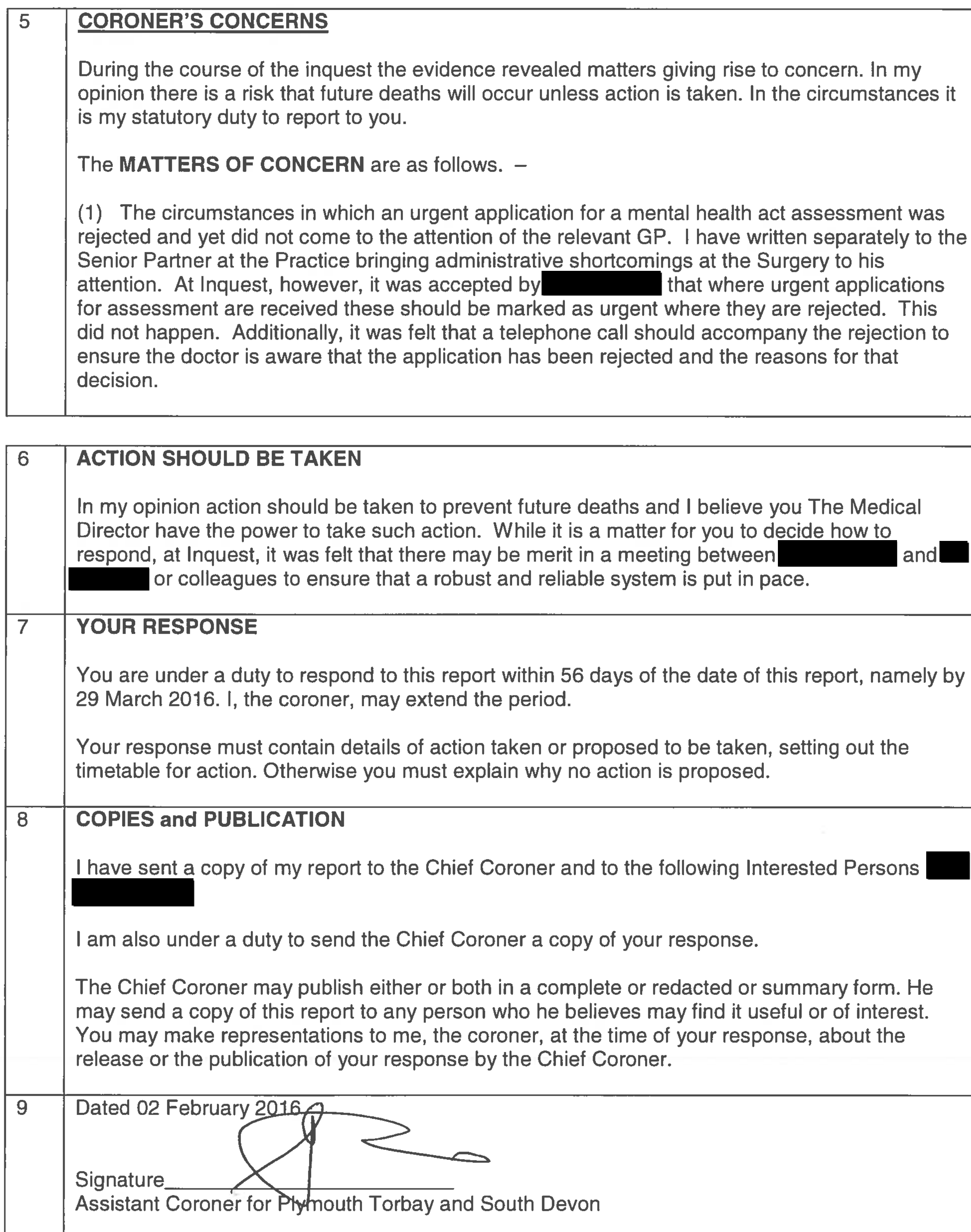

5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) The circumstances in which an urgent application for a mental health act assessment was rejected and yet did not come to the attention of the relevant GP. I have written separately to the Senior Partner at the Practice bringing administrative shortcomings at the Surgery to his attention. At Inquest, however, it was accepted by that where urgent applications for assessment are received these should be marked as urgent where they are rejected. This did not happen. Additionally, it was felt that a telephone call should accompany the rejection to ensure the doctor is aware that the application has been rejected and the reasons for that decision.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you The Medical Director have the power to take such action. While it is a matter for you to decide how to respond, at Inquest, it was felt that there may be merit in a meeting between and or colleagues to ensure that a robust and reliable system is put in pace.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 29 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.
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