

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO: Neil Carr OBE, Chief Executive, South Staffordshire and Shropshire NHS Foundation Trust, Trust HQ, St George's Hospital, Corporation Street Stafford, ST16 3SR</p>
1	<p>CORONER</p> <p>I am Mr Andrew Haigh senior coroner for the coroner area of Staffordshire South</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 29 September 2014 I commenced an investigation into the death of Angela Catherine Brealey, aged 57 years. The investigation concluded at the end of the Inquest on 22 December 2015. The conclusion of the inquest was that Angela Brealey hanged herself while suffering severe depression with psychotic ideas.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Angela Brealey was found dead in her home on 19 September 2014. She had hanged herself. She was in receipt of treatment from local secondary psychiatric services although no full assessment of her condition had been carried out by a Consultant Psychiatrist.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows:</p> <p>(1) At the Inquest I heard various evidence about what should happen to information received from third parties concerning a person receiving treatment from the Trust. This does feature in the action plan prepared following the Inquest but I think the process should be looked at on quite a wide basis. Should information received from a third party be acknowledged at all? If so, how? How much of lengthy communications received from third parties should be recorded? Is entry on the RIO medical notes sufficient in itself? How is patient confidentiality protected in these circumstances and what about circumstances where third parties request confidentiality for information they have provided?</p> <p>(2) During the period that Angela was receiving assistance from the Trust there is minimal evidence of a multi-disciplinary team being involved.</p>

	<p>Predominantly one community mental health nurse took responsibility. While it may not have affected the outcome in this case a team approach involving a number of professionals may have been preferable. Is this something that the Trust needs to look at?</p> <p>(3) Generally the serious incident review process is a very helpful one. In this particular case however a number of concerns about Angela's treatment were not picked up by the review. Is pressure on those carrying out this process reducing the effectiveness of the reports?</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>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.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 18 February 2016. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [REDACTED] and [REDACTED] of Messrs Capsticks, Solicitors. I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>24 December 2015</p> <p>Andrew A Haigh HM Senior Coroner Staffordshire (South)</p> <p>Coroner's Office No 1 Staffordshire Place Stafford ST16 2LP Tel No: 01785 276127 Fax No: 01785 276128</p>

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