REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive, Cornwall Partnership NHS Foundation Trust** **The Chief Executive, NHS Kernow Clinical Commissioning Group**
1	**CORONER** I am Guy Davies, Her Majesty's Assistant Coroner for Cornwall and the Isles of Scilly.
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** In June 2015 an investigation commenced into the death of 58 year old Simon Jonathon Klineberg. The investigation concluded at the end of the inquest on 19th May 2016. The conclusion of the inquest was that Mr Klineberg died from a self-inflicted, reckless and impulsive overdose of prescription medication, administered to address acute head pain, possibly caused by his psychological condition.
4	**CIRCUMSTANCES OF THE DEATH** Jonathon suffered serious mental health problems for the last 18 months of his life and was diagnosed with agitated depression and generalized anxiety. Jonathan was hospitalized after near fatal self-harm incidents in May 2014 and November 2014 following which an extensive psychological assessment was conducted. Individual psychological therapy was recommended in February 2015, but was delayed due to waiting lists and never commenced. Psychological therapy may have reduced the risk of death in this case. It is not possible to say on the balance of probabilities whether Jonathan would have survived if he had been able to access individual psychological therapy. During the course of his illness Jonathan developed increasingly severe intermittent head pains possibly rooted in his emotional and psychological condition. The pain Jonathon felt led to impulsive and reckless self-medication in an attempt to reduce that pain. Reckless self-medication led to an overdose on 27th May 2015 and a further admission to hospital. Jonathon was discharged home the following day and referred for assessment to the Home Treatment Team (HTT) on the basis that he was considered to be a significant risk to himself. The function of the HTT is to provide intensive treatment or critical care to people in their own home who are in an acute mental crisis, who without such support might require hospital admission. The HTT assessed Jonathan on the 29th May 2015 and found him to be a high risk to himself. The HTT decided not take him onto their caseload or to admit him to a psychiatric unit. Jonathon was referred by the HTT to the integrated community mental health team.

	Admission to hospital or support from HTT from 29/5 may have reduced the risk of death in this case. It is not possible to say on the balance of probabilities whether Jonathon would have survived if he had been taken onto the HTT caseload. Before any further treatment could commence a further reckless overdose caused his death in the early hours of 7th June 2015.
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) To review the availability of beds for psychiatric patients in Cornwall. Kernow Clinical Commissioning group (KCCG) to respond (2) To review the allocation of resources to the home treatment team, with particular reference to the threshold for offering support. Both Kernow Clinical Commissioning group (KCCG) and Cornwall Partnership NHS Foundation Trust (CFT) to respond (3) To review the waiting lists for individual psychological therapy. Cornwall Partnership NHS Foundation Trust (CFT) to respond. (4) To review procedures for prioritizing high risk patients in waiting lists for psychological therapy. Cornwall Partnership NHS Foundation Trust (CFT) to respond.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe Cornwall Partnership NHS Foundation Trust and NHS Kernow Clinical Commissioning Group 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 Tuesday 19th July. 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 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	**Guy Davies 24th May 2016**