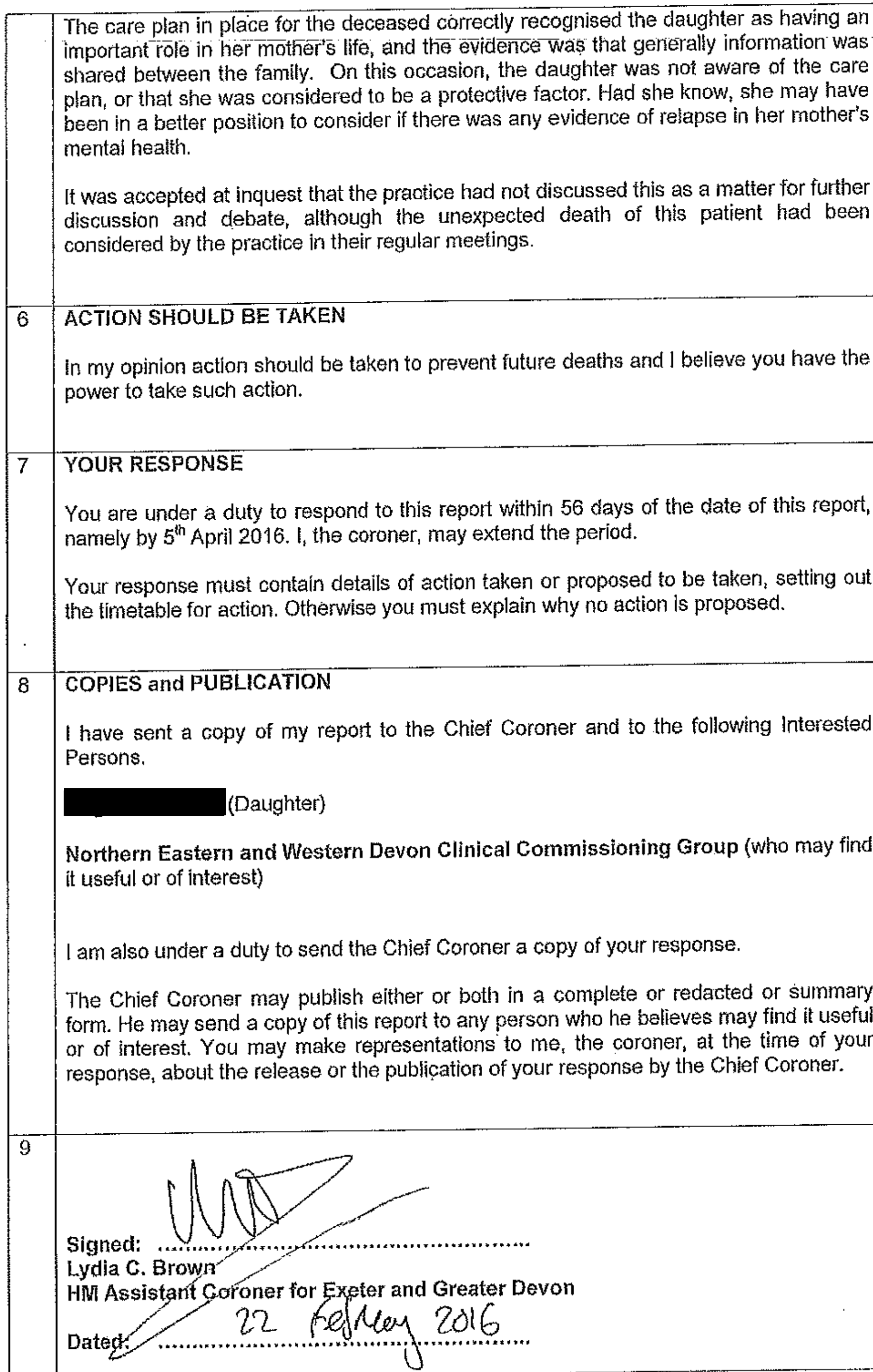
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [REDACTED] **- Bampton Surgery** Barnhay Bampton Devon EX16 9NB
1	**CORONER** I am Lydia Brown Assistant Coroner for the coroner area of Exeter and Greater Devon.
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 22 June 2015 I commenced an investigation into the death of Patricia Mary Medland. The investigation concluded at the end of the Inquest on 12 January 2016. The conclusion of the inquest was - open conclusion.
4	**CIRCUMSTANCES OF THE DEATH** The deceased died due to exposure to heat and fire smoke, from a fire commenced by herself using petrol as an accelerant. There was no evidence of third part involvement. At the time of her death, the deceased was suffering from a severe mental illness and it is likely that this impacted on her actions. A care plan had been prepared, reviewed and agreed with the general practitioner and the deceased. It made reference to the daughter being a protective factor in the safety of the deceased, but the daughter did not know of the existence of the care plan, of her mother's current diagnosis, or that she was named within the document.
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. –



The care plan in place for the deceased correctly recognised the daughter as having an important role in her mother's life, and the evidence was that generally information was shared between the family. On this occasion, the daughter was not aware of the care plan, or that she was considered to be a protective factor. Had she know, she may have been in a better position to consider if there was any evidence of relapse in her mother's mental health.

It was accepted at inquest that the practice had not discussed this as a matter for further discussion and debate, although the unexpected death of this patient had been considered by the practice in their regular meetings.

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 5th April 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] (Daughter)

Northern Eastern and Western Devon Clinical Commissioning Group (who may find it useful or of interest)

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.

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Signed: ....

Lydia C. Brown
HM Assistant Coroner for Exeter and Greater Devon

Dated: 22 February 2016