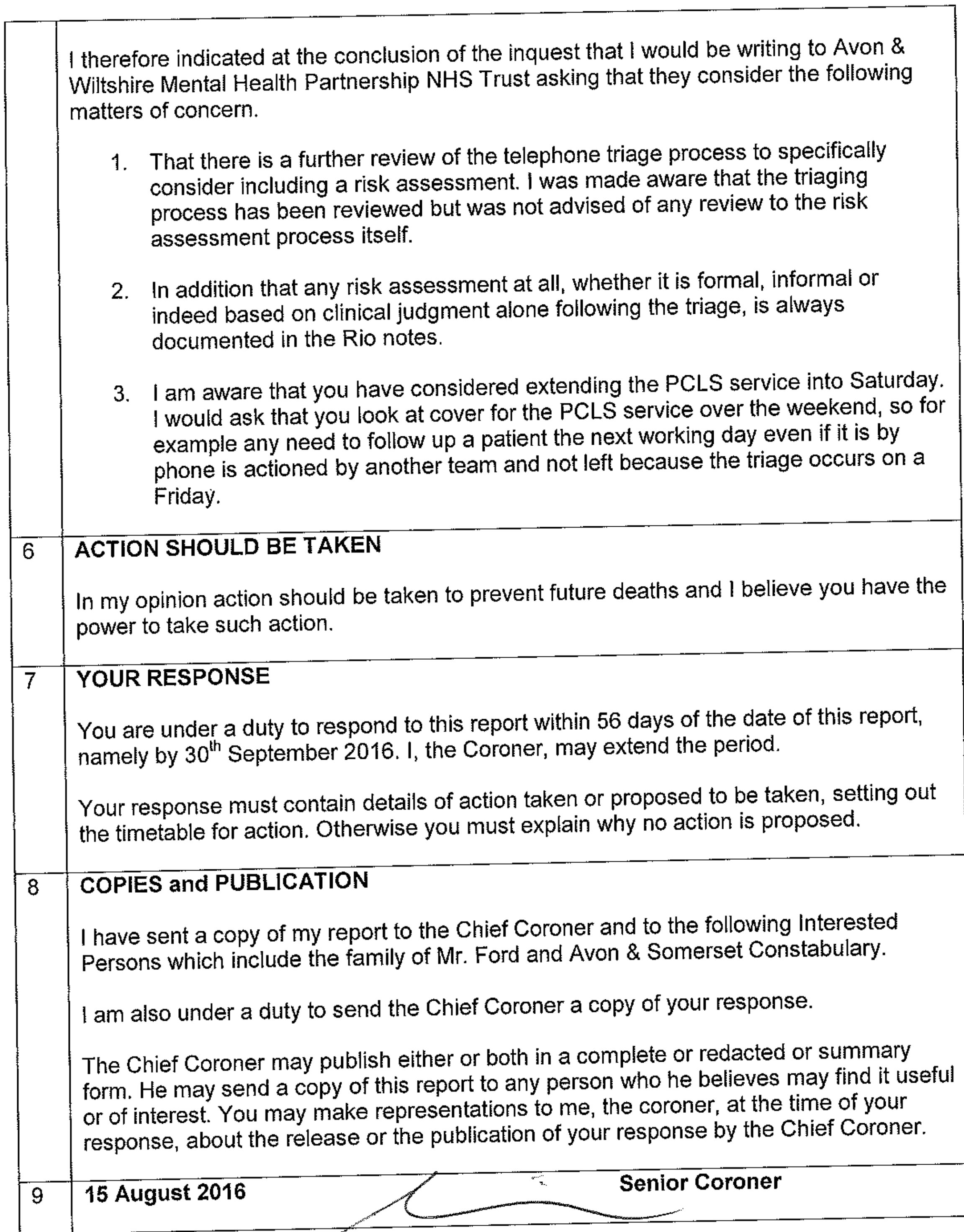
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Dr. H. Richards** **Chief Executive** **Avon & Wiltshire NHS Partnership NHS Trust** **Jenner House** **Langley Park Estate** **Chippenham** **SN15 1GG**
1	**CORONER** I am Maria Voisin, Senior Coroner, for the Area of Avon
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 24th August 2015 I commenced an investigation into the death of **Oliver Hamlin FORD**, Aged **25**. The investigation concluded at the end of the inquest on 10th August 2016. The medical cause of death was given as: Ia) Suspension by ligature (Hanging) The conclusion of the inquest was a narrative which read as follows: **Oliver Ford was under the care of the mental health service at the time of his death. He had been triaged but no formal risk assessment had been carried out. He was found hanging from a tree in woodland his intention is unknown.**
4	**CIRCUMSTANCES OF THE DEATH** Oliver Ford had a diagnosis of social anxiety disorder with substance misuse. In the week leading up to his death he had taken heroin and amphetamines. On 13th and 14th August he began to express paranoid thoughts. On the 14th August he was triaged by the Primary Care Liaison Service, a risk assessment was not carried out. This was confirmed in evidence by both the registered mental health nurse and indeed the consultant psychiatrist who provided an overview of Oliver's care. At the end of the triage the plan was to speak to him again on Monday, he was advised not to take drugs over the weekend and was provided with the details of the intensive support team. On 15th August he was reported missing and on 16th August he was found dead by a member of the public hanging from a tree at Norton Wood, Clevedon. I was told in evidence by the registered mental health nurse that the PCLS only operate from Monday to Friday. Her plan would have been to ring him the next working day as that was Monday that's why the Monday was put in the plan.
5	<u>**CORONER'S CONCERNS**</u> 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 two areas of concern which were raised at the inquest were in relation to the triaging process and specifically assessing a person's risk during that triage together with the cover for the PCLS over weekends.



	I therefore indicated at the conclusion of the inquest that I would be writing to Avon & Wiltshire Mental Health Partnership NHS Trust asking that they consider the following matters of concern. 1. That there is a further review of the telephone triage process to specifically consider including a risk assessment. I was made aware that the triaging process has been reviewed but was not advised of any review to the risk assessment process itself. 2. In addition that any risk assessment at all, whether it is formal, informal or indeed based on clinical judgment alone following the triage, is always documented in the Rio notes. 3. I am aware that you have considered extending the PCLS service into Saturday. I would ask that you look at cover for the PCLS service over the weekend, so for example any need to follow up a patient the next working day even if it is by phone is actioned by another team and not left because the triage occurs on a Friday.
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 30th September 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 which include the family of Mr. Ford and Avon & Somerset Constabulary. 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	**15 August 2016** **Senior Coroner**