REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. Chief Executive

South Staffordshire & Shropshire Healthcare NHS Foundation Trust Trust Headquarters

St George's Hospital

Corporation Street

Stafford

ST16 3SR

1 CORONER

I am Mrs Margaret Joy Jones, Assistant coroner for the coroner area of Staffordshire South

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 25.10.2016 I commenced an investigation into the death of Lester John STACEY. The investigation concluded at the end of the inquest on 9.3.2017. The conclusion of the inquest was Suicide the cause of death was hanging.

4 CIRCUMSTANCES OF THE DEATH

The deceased had a history of hypertrophic cardiomyopathy and mental health issues. He had been diagnosed with bi-polar affective disorder. He had contact with mental health services from 2005 to 2014 and was re-referred in May 2016. He received some in-patient care but on discharge he failed to engage with community services and was subsequently discharged. His medication was changed at this time. He had recently had some worries regarding his business and had been suffering with low moods. At about 1800 hours on the 23rd October 2016 he was found hanging in a barn at his home address, The Oaks, Green Lane, Eccleshall. He was certified dead at the scene. There was no third party involvement.

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 deceased was admitted as an In-patient under S2 Mental Health Act from 16 May 2016 to 19 May 2016. He was discharged without being given follow up appointments. He subsequently failed to respond to telephone calls and letters to attend appointments. He was therefore discharged from the service on the 21 June 2016.

There was no attempt to visit him during this period to try and re-engage him with services. He may not have received the correspondence inviting him for appointments because he was away on holiday for some of that period. He might have benefitted from having pre-arranged appointments prior to his discharge. His medication was changed during his last admission and thereafter does not appear to have been monitored. The deceased was said to have lacked confidence in the new medication and may not have been totally compliant. Family perception was that he responded less well to the changed medication.

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 May 2017I, 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 Person,

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 10th March 2017

es Ass

Margaret J Jones Assistant Coroner Staffordshire (South)

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