REGULATION 28: REPORT TO PREVENT FUTURE DEATHS
David John Buttriss deceased

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr Phillip Confue, The Chief Executive of Cornwall Partnership Foundation Trust** **2. [redacted], Director of Cornwall Health** **3. Chief Executive of NHS England**
1	**CORONER** I, Dr E Emma Carlyon am the Senior Coroner for the coroner area of 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** An investigation was opened on 13th May 2016 into the death of **DAVID JOHN BUTTRISS** who died on 9th May 2016 at his home address Western Meadows, Under Lane, Launceston. An inquest was opened on 16th May 2016 and a full Inquest hearing was held between the 6-7th September 2017 at Truro Municipal Buildings. The Inquest found the cause of death as 1a Massive haemorrhage 1b Penetrative trauma to the right neck and the conclusion was "Suicide".
4	**CIRCUMSTANCES OF THE DEATH** David Buttriss had been aggressive towards his parents on the morning of the 9th May 2016 and produced a Stanley knife at the time and was threatening to kill himself. His parents phoned the police at 10.21am. While his father was on the phone to the police David stood at the top of the stairs on the landing and said "Call them off, I'm not a danger to you or mum. They'll take me away. Don't do this". David then cut himself at around 10.41 am and became unconscious. Despite medical assistance and resuscitation from his father, the police and paramedics he was confirmed dead at 11.35 am. A hand written note was found in the rear of annotated book "Loving Someone with Border-Line Personality" stating "Every night is a Friday night and every morning is a Monday Morning.

Love you all. So very sorry. Dave X." He suffered from long term mental health issues which had deteriorated after he failed to rekindle a significant relationship in the weeks prior to his death. In addition the use of cannabis and the effect of an anaesthetic had adversely affected his mood. There had been input from his GP, the Community Mental Health Team and the Home Treatment team and out of Hours doctors and paramedic in order to address his deteriorating mental health.

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. Mr Buttriss had contact with a number of health agencies in the weeks prior to his death including the Community Mental Health, Home Treatment team, GP, Out of Hours GP and Paramedics. It was clear from the evidence at inquest that

    - There were Communication issues between the GP and mental health service. The mental health services had requested a patient profile from the GP on 14.5.16 which was not received. The Patient's GP did not advise mental health services that Mr Buttriss had a mental health history pre-2009 when spoken to following his first self-referral on 14.5.16. It was not known whether this may have affected the decisions the mental health professionals took but it did and meant that his mental health issues were not known to the Cornwall Mental Health Service when they were contacted at the time of crisis

    - The health care records for the GP and the Mental Health services are held on different health care record systems held by the different healthcare providers. This meant that the GP did not have access to the mental health service records at the time of the consultation on by [redacted] on 25th April nor did the mental health workers have information about the appointment with [redacted] nor were they aware of the medication issues. The Out of Hours GP, [redacted] did not have access to either the mental health or GP records and was in a difficult position when deciding how to deal with Mr Buttriss especially with regards to prescribing and sign posting to mental health professionals when she saw him in acute crisis on the 7th May.

    - It was clear from the evidence of the Paramedic and [redacted]

	████ and the parents that there was lack of clarity of the appropriate method or pathway to deal with Mr Buttriss on the night of 7th May when he was in crisis. The paramedic did speak to the Home Treatment Team for advice but as Mr Buttriss was reluctant to engage no intervention was made. There appeared to be confusions between the role of the Community Mental Health Service and the Home Treatment Team and the role of the Home Treatment Team Out of Hours provision.
	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation have the power to take such action. 1. To review the methods of requesting and obtaining relevant information on a patient between health agencies for the purpose of treating a patient in timely manner e.g. Patient profile requests from mental health services and mental health input summaries to GP especially at time of quick deterioration in health/mental health or crisis. 2. To review the possibility of secure health record sharing between mental health agencies, Hospitals, GP's and out of hours health agencies e.g. Out of Hours GP, Home Treatment Teams and paramedic and Hospital Emergency Departments 3. To clarify to health professionals (and if possible to patients and public) the roles and responsibilities of each health Agencies especially outside normal working hours and weekends so that patients are referred to the correct agency and are aware of the safety nets in place if their health deteriorates 4. To consider GP's making a routine follow up after referral or signposting to other agencies to ensure that referral has been followed up and the outcome know.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by the 12th March 2018. 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] of the Devon and Cornwall Police, [redacted] - IPCC [redacted] - South West Ambulance Service. I have also sent it to [redacted] Investigating Officer of the Devon and Cornwall Police and the [redacted] CIC (new Out of Hours Service) 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.
9	**[DATE]** **[SIGNED BY CORONER]** **12/01/2018** Elizabeth Emma Carlyon