HM Assistant Coroner
for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Chief Executive Avon and Wiltshire Mental Health Partnership NHS Trust Bath NHS House Newbridge Hill Bath BA1 3QE **and for information purposes to:** NHS Improvement NHS England Care Quality Commission
1	**CORONER** I am Nicholas Leslie Rheinberg an Assistant Coroner for Wiltshire and Swindon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 27th October 2016 an investigation was commenced into the death of Terence Andrew Bennett aged 45. On the 14th September 2014 the inquest was concluded. I sat with a jury. The jury found that the medical cause of death was **1a) Incised wounds to neck 2 Coronary Artery Disease.** The jury concluded that the deceased died by suicide; his death was contributed to by neglect
4	**CIRCUMSTANCES OF THE DEATH** The deceased suffered from schizo-affective disorder and had done so for more than 20 years. In acute phases of his illness he posed as a high risk to both himself and others. In August 2016 he began to relapse and by 25th October 2016 he was severely mentally ill, suicidal and threatening physical harm to his Mother. During the evening of 26th October 2016, he self-inflicted 19 deep lacerating wounds to his neck, partly severing the jugular vein and a great number of incised wounds to his left and right wrists. He physically resisted attempts to save him and following collapse was pronounced dead at 32 minutes past midnight on 27th October 2016
5	**CORONER'S CONCERNS** During the course of the inquest it emerged that there were gross failures in respect of the care provided to the deceased by your trust to the extent that the jury found that the deceased's death had been contributed to by neglect. My specific concerns are as follows: 1. Care, Risk and Crisis Management plans were not robust enough and failed to contain sufficient information. 2. Staff had insufficient knowledge of how to access, interrogate and effectively use computerised medical records, in respect of a generic system which itself did not sufficiently cater for the particular requirements of Avon and Wiltshire Mental Health Partnership NHS Trust.

	3. There was a lack of involvement of family members and in particular, the concept of a triangle of care which involved family, the patient and the medical team had largely been ignored. 4. There did not appear to be a system of peer review within the mental health teams nor a system of external audit as regards the adequacy of care plans and medical records. 5. Unqualified staff were relied upon in circumstances where qualified staff should have been assigned. 6. There appeared to be deficiencies in the supervision of unqualified mental health workers. 7. There was little evidence of multi-disciplinary working in relation to an individual with complex mental health needs. 8. When there was a change in personnel responsible for the care of the patient, there appeared to be a lack of a proper handover between the healthcare professionals. 9. Much of the above implied serious gaps in the adequacy of training / knowledge, the allocation of time, the acquisition and deployment of necessary skills and the establishment of satisfactory ways of working. 10. The on-call rota for duty consultants meant that consultant psychiatrists on occasions faced a full day of clinical work immediately following the completion of a 12 hour night time duty, without any period of rest and recuperation.

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 10th November 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, NHS Improvement, NHS England and to the family of the deceased. 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 assistant coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	Dated 14th September 2018 Signature_____ Nicholas Leslie Rheinberg Assistant Coroner for Wiltshire & Swindon