REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

David Morley Sargeant, deceased

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Ms Jackie Pendleton, Chief Officer, NHS Kernow Clinical Commissioning Group
1	**CORONER** I am Guy Davies, Her Majesty's Assistant Coroner for Cornwall & 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** On 22nd June 2017 I commenced an investigation into the death of 48 year old David Morley Sargeant. The investigation concluded at the end of the inquest on 18th October 2018. The conclusion of the inquest was as follows; David Morley Sargeant died on 16th June 2017 at The Ford, Mawgan, Helston, Cornwall, from the toxic effects of an intentional overdose of prescribed and controlled drugs. My conclusion as to the death is that it was Suicide. The medical cause of death was established on the evidence as: 1a) disease or condition directly leading to death - Mixed drug toxicity II) other significant condition(s) which could have contributed to the death but are not related to the disease or condition causing it – suspension by ligature around the neck.
4	**CIRCUMSTANCES OF THE DEATH** David Sargeant (known to family and friends as Davy) was found deceased in a car in a rural location following an intentional overdose. The doors were locked, the only set of keys were inside the vehicle. Davy had a ligature around his neck which the pathologist considered as secondary measure taken by Davy as part of his intention to kill himself. Davy had a history of drug abuse. Davy had received treatment from the Cornwall drug addiction treatment service, Addaction. Davy displayed a historical pattern

	of chaotic illicit substance misuse. These periods were usually followed by periods of treatment and stabilisation, which included substitute prescribing and/ or rehabilitation. The Addaction report stated that during these more stable periods in his life he appeared to become more vulnerable to his 'ADHD and 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. – In October 2016 Davy was referred by his GP to the community mental health team (CMHT), part of Cornwall Partnership NHS Foundation Trust (CPT) for assessment of possible 'Attention deficit hyperactivity disorder' (ADHD) which is a group of behavioural symptoms that include inattentiveness, hyperactivity and impulsiveness. Davy was assessed in December 2016 by CMHT. However, Davy was discharged from CMHT without further diagnosis and treatment. This was because of the following reasons;- 1) CPT is not commissioned to assess, diagnose or treat adult ADHD. 2) Addaction Cornwall does not have access to a specialist psychiatrist with the skills to diagnose or treat ADHD. 3) Although the GP had the option to refer under Patient Choice for treatment out of county, the GPs previous experience indicated that this was impracticable because it would not be possible to successfully deliver the ongoing oversight and review of medication. In summary, Davy could not be diagnosed and treated by specialist services either in Cornwall or out of county.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action. I recommend that NHS Kernow reviews the arrangements for the diagnosis and treatment of ADHD by specialist services either in Cornwall or out of county, with consideration being given to the following concerns

	1) CPT is not commissioned to assess, diagnose or treat adult ADHD. 2) Addaction Cornwall does not have access to a specialist psychiatrist with the skills to diagnose or treat ADHD. 3) Although GPs have the option to refer under Patient Choice for treatment out of county, experience indicates that this is impracticable because it would not be possible to successfully deliver the ongoing oversight and review of medication. I would be pleased to hear from you in relation to these concerns.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 20th December 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] – Davy's mother. I have also sent it to the following who may find it useful or of interest. Phil Confue, Chief Executive, Cornwall Partnership NHS Foundation Trust [redacted]y, Operations Director, Addaction. [redacted] Co-coordinator, Drug action team, Cornwall Council 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	**25/10/18** **Guy Davies**