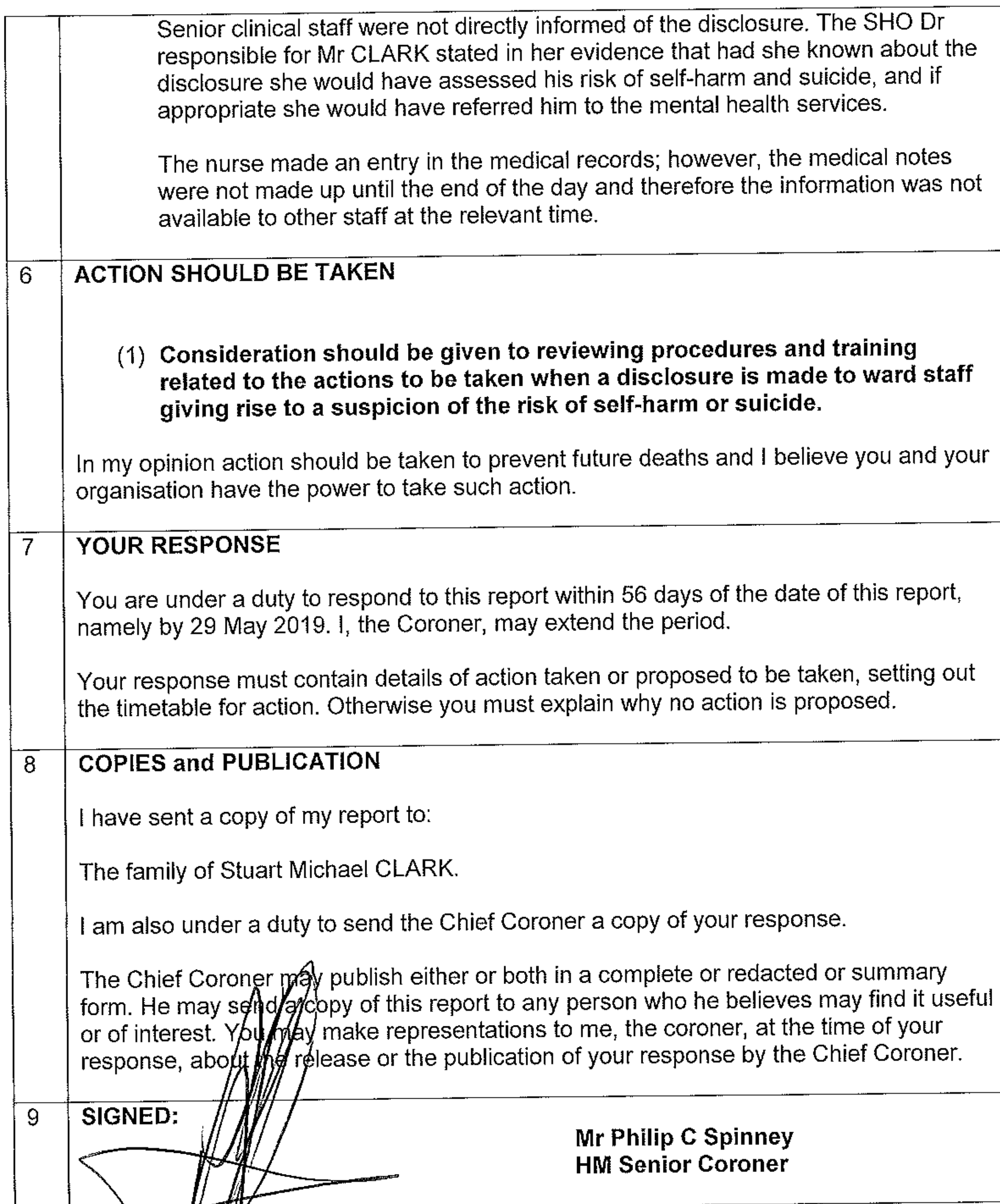
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT DATED 3 APRIL 2019 IS BEING SENT TO:** 1. Ms Suzanne Tracey, Chief Executive of Royal Devon and Exeter NHS Foundation Trust
1	**CORONER** I am Philip Charles SPINNEY, HM Senior Coroner, for the Coroner area of Exeter and Greater Devon.
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 3 October 2017 an investigation was commenced into the death of Stuart Michael CLARK. The investigation concluded at the end of the inquest held on 2 April 2019. The conclusion of the inquest was as follows: Suicide
4	**CIRCUMSTANCES OF THE DEATH** Stuart Michael CLARK had a long history of suffering with his mental health. On 3 October 2017 he jumped into the canal at Haven Road, Exeter wearing a rucksack filled with weights. He was recovered from the water and taken to the Royal Devon and Exeter Hospital where he sadly died shortly after arriving. More specifically, Mr CLARK had a history of Asperger's Syndrome, Dyspraxia, Developmental Dyslexia and Irlen's Syndrome. In the weeks before he died he complained of a rash, pain and swelling believed to be an allergic reaction. On 30 September 2017 he was admitted to the Royal Devon and Exeter Hospital due to pain, swelling and a history of diarrhoea and nausea; on assessment he was extremely anxious and concerned about his physical illness. During his admission he disclosed to a nurse on the ward that he was a vulnerable adult and a suicide risk. This information was not escalated, and no assessment was made to determine his risk of self-harm and suicide.
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) The evidence revealed that Mr CLARK disclosed to a member of nursing staff on Lowman (Capener) Ward at the Royal Devon and Exeter Hospital that he was a vulnerable adult and a suicide risk. This disclosure was not followed up with an assessment to determine if Mr CLARK had any intent, plan or history of self-harm or suicide. An assessment would have helped determine his risk and inform the decision on a referral to mental health services.



	Senior clinical staff were not directly informed of the disclosure. The SHO Dr responsible for Mr CLARK stated in her evidence that had she known about the disclosure she would have assessed his risk of self-harm and suicide, and if appropriate she would have referred him to the mental health services. The nurse made an entry in the medical records; however, the medical notes were not made up until the end of the day and therefore the information was not available to other staff at the relevant time.
6	**ACTION SHOULD BE TAKEN** (1) **Consideration should be given to reviewing procedures and training related to the actions to be taken when a disclosure is made to ward staff giving rise to a suspicion of the risk of self-harm or suicide.** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 29 May 2019. 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 family of Stuart Michael CLARK. 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	**SIGNED:** **Mr Philip C Spinney** **HM Senior Coroner**