Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

ANNEX A

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*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive Sussex Partnership NHS Trust**
1	**CORONER** I am Joanne Andrews, assistant coroner, for the coroner area of West Sussex.
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 11 September 2018 I commenced an investigation into the death of George Edward Rogers, 30. The investigation concluded at the end of the inquest on 11 November 2019. The conclusion of the inquest was that Mr Rogers died as a result of an intentional act by him take his own life by causing a fatal laceration to his chest. I therefore gave a conclusion of suicide.
4	**CIRCUMSTANCES OF THE DEATH** 1. Mr Rogers had a diagnosis of body dysmorphic disorder. He was previously treated for the condition and recovered. He was resident in Australia in 2017 when he started to become unwell again with BDD and returned to the UK in February 2018. 2. On his return to the UK Mr Rogers' parents took him to his GP who referred Mr Rogers to the Acute Treatment Service (ATS). 3. Before that referral could take effect Mr Rogers attempted to take his own life by causing a laceration to his chest which resulted in an admission to Southampton General Hospital. This was a life threatening injury. 4. On discharge from Southampton General Hospital on 23 February 2018 Mr Rogers was placed under the care of the Crisis Resolution and Home Treatment Team (CRHTT). 5. Mr Rogers was treated by the CRHTT until he was transferred to the care of the ATS on 9 April 2018. On transfer between CHRTT and ATS Mr Rogers was not appointed a Lead Practitioner to coordinate his care. 6. Mr Rogers was assessed by ATS on 11 April 2018. Mr Rogers heard nothing more from ATS until 23 April 2018 following his family's intervention having heard nothing. A Lead Practitioner was appointed on 23 April 2018. Mr Rogers was not receiving treatment or being seen by ATS between 11 April 2018 and 14 May 2018 and had no treatment or ongoing assessment of risk during this period. It was accepted in evidence by Sussex Partnership NHS Trust that the lack of appointment of a Lead Practitioner for Mr Rogers resulted in delay in his treatment. 7. Mr Rogers received treatment from ATS up until his death on 28 August 2018.

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 could 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. When transferring patients between the CHRTT and ATS there is not always a Lead Practitioner appointed on transfer which may (a) delay patients receiving treatment and (b) mean that patients may not be monitored pending the appointment.
6	**ACTION SHOULD BE TAKEN** 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 10 January 2020. 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]. 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	J. Andrews **Joanne ANDREWS** **Assistant Coroner for** **West Sussex Coroner's Service** **Dated: 21/11/2019**