REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Ms Angela McNab, Chief Executive, Kent and Medway NHS and Social Care Partnership Trust ("the Trust").
1	**CORONER** I am Christopher Morris, assistant coroner for the coroner area of Central & South East Kent
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 29th April 2015, an inquest was opened into the death of Julie Margaret Rose who was found dead on 26th April 2015, aged 54 years. I held a Pre-Inquest Review on 2nd September 2015, and conducted an inquest on 9th December 2015 at Folkestone Magistrates Court. The conclusion of the inquest was suicide, the medical cause of death being suspension.
4	**CIRCUMSTANCES OF THE DEATH** On 24th April 2015, Miss Rose (who was well-known to the Trust's Community Mental Health and South East Kent Crisis Resolution Home Treatment Team as a result of long-standing depression, anxiety and Obsessive Compulsive Disorder) was brought to St Martin's Hospital, Canterbury by police under s136 Mental Health Act following a concern that she intended to take her own life. Following assessment by an Approved Mental Health Professional, Consultant Psychiatrist and independent (s12) doctor, Miss Rose was discharged from s136 with a plan in place for support at home by the Crisis Resolution Home Treatment Team and a medication review. On 25th April 2015, Miss Rose was visited at home by two members of the Crisis Resolution Home Treatment Team who noted her to be low in mood. Miss Rose agreed to undertake tasks and techniques intended to improve her state of mind. At approximately 14:50, a supportive telephone call was made to Miss Rose who reported she felt suicidal. The specialist support worker who spoke with Miss Rose again made suggestions as to steps she could take to improve her mood. Further attempts to contact Miss Rose by telephone at 17:00, 18:00 and 22:30 were unsuccessful, as was an attempted home visit at around 09:25 on 26th April 2015. Although at least one team member expressed concerns that it was unusual not to be

	able to contact Miss Rose, no attempts were made to contact family members who also supported her. Additional attempts were made without success to contact Miss Rose by telephone, and following a further attempted home visit at around 16:00 (over 24 hours after Trust staff had managed to make any contact with Miss Rose), Kent Police was contacted and a welfare check requested. Officers forced entry to Miss Rose's home, where she was found dead.
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. Whilst I heard evidence at the inquest of the considerable efforts the Trust has made to reflect on the circumstances of Miss Rose's death and mitigate the risk of similar deaths occurring, it is my opinion that there remain matters of concern. These residual **MATTERS OF CONCERN** are as follows. – (1) Although the Trust's Unable to Make Contact Protocol ("the Protocol") has been reviewed since Miss Rose's death, I am concerned that it is insufficiently clear as to when Crisis Resolution Home Treatment Team members should request a police welfare check in respect of patients who have been identified as 'Red' for the purposes of the Trust's R A G Rating System. In particular, I am concerned the Protocol does not specifically stipulate circumstances where a request for a welfare check is mandatory (for example, after a certain period of time has elapsed since contact was last made, and / or after a certain number of attempts at contact and / or after attempts at telephone contact and a home visit have both been unsuccessful); (2) In the course of the hearing, I heard evidence that the Protocol has been 'reinforced' across the Crisis Resolution Home Treatment Team. Notwithstanding this, a shift co-ordinator who gave evidence was clearly not conversant with the Protocol, raising questions as to the adequacy of the steps taken by the Trust to date in this respect.
	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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 1st February 2016. 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 : 1. [redacted] 2. I have also sent it to the Care Quality Commission 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	**14th December 2015**

Cc. Mrs Katriona Learmond - Head of Legal Services (Solicitor)