ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Devon Partnership Trust** **Wonford House** **Dryden Road** **Exeter** **EX2 5AF**
1	**CORONER** I am John Geoffrey Tomalin, assistant 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 23rd May 2017 I commenced an investigation into the death of Naomi Clare SOURBUT aged 26 years. The investigation concluded at the end of the inquest on 19th December 2017. The medical cause of death was: 1a Hypoxic Brain Injury 1b Medication Overdose (most probably Venlafaxine) A narrative conclusion was given as follows: Naomi Clare Sourbut died from Hypoxic Brain Injury following a self-administered overdose of medication, most probably Venlafaxine, a drug prescribed to treat her depression.
4	**CIRCUMSTANCES OF THE DEATH** Ms Sourbut had a history of anxiety and depression. In her late teens she self-harmed and this continued, she also became bulimic. She engaged with Primary Care practitioners and Secondary Care in the form of the Community Mental health team. She engaged with that team between May and December 2016 and re-engaged in March 2017 by referral from her GP. She was prescribed the anti-depressant Venlafaxine. Ms Sourbut had met with her Community Mental Health practitioner on the 27th March 2017, discussed her condition and this person had previously been her care co-ordinator. A new care co-ordinator was to be appointed with effect from the 3rd April 2017. There was a review of her medication and recommendations were sent to her GP. Ms Sourbut was advised to contact the duty team at the CMHT should she feel

	unwell. She was also under the care of a private therapist to assist with her eating disorder. 31st March 2017 following a conversation with her General Practitioner, she contacted the Community Mental Health practitioner duty officer advising that she was self-harming, she also advised that she had suicidal ideation and also sufficient medications to overdose on. Though asked by the officer who spoke with her if she would take the overdose she denied this. She was agreeable to input from the Crisis Resolution Home Treatment team (CRHT) and the duty officer agreed to make a referral call and let her know what the CRHT team said. The officer contacted the CRHT who accepted the referral. The officer then made one attempt to contact Ms Sourbut when she did not answer her mobile telephone and left a message on her voicemail advising her that CRHT team would be in contact that evening and encouraged her to contact 999 or present herself to the Royal Devon and Exeter Hospital if she was concerned for her safety and about to take an overdose. Ms Sourbut's GP attempted to contact her at 6pm that same day and left a message. She called again at 6.43pm but was unable to speak with Ms Sourbut so the GP called the landline at her parent's home, her father then discovered his daughter unconscious in her room. Ms Sourbut was then taken by ambulance to the Royal Devon and Exeter Hospital where she died on the 2nd April 2017.
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) A root cause analysis investigation was undertaken by the Devon Partnership Trust and that report was finalised on the 8th September 2017. The report contained a number of identified lessons learned and recommendations, ten in total (see attached annexe), applicable to different teams within Devon Partnership Trust. It was unclear at the Inquest as to whether or not these recommendations have been considered and acted upon by the teams to which they were directed particularly where clients have talked of suicidal ideation and identified the means with which to bring about their death. In my opinion action should be taken to prevent future deaths and I believe you and your organisation has to take such action to confirm the recommendations in the root cause analysis report File No: 2017/10523 NON ANON RCA JHNS 18.9.17 – having been considered and implemented. (2) In addition where an individual has indicated an intent to cause themselves harm and have advised clinicians they have access to the means to cause that harm then protective factors should be put in place to help reduce the risk of the individual harming themselves in the way they have indicated or otherwise.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 26th March 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] **GP Bethune – St Leonard's Practice** 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	**[DATE]** **[SIGNED BY CORONER]**