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SENIOR CORONER · BUCKINGHAMSHIRE

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, Oxford Health NHS Foundation Trust**
1	**CORONER** I am CRISPIN GILES BUTLER, senior coroner for the coroner area of Buckinghamshire
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. http://www.legislation.gov/uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/pdfs/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 1st July 2019 I commenced an investigation into the death of Roy Keith MORRIS, aged 60 years. The investigation concluded at the end of the inquest on 26th March 2021. The medical cause of death was hanging. The narrative conclusion of the inquest was: Roy Morris died as a result of suicide to which the following contributed more than minimally: (a) that the fact that there was no detailed written care plan for Roy on discharge as an inpatient into the care of the community and acute day hospital teams; (b) the fact that his care coordinator was only allocated shortly before discharge; and (c) the fact that Roy's family were not provided with the means to engage fully and candidly with the inpatient team.

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4	**CIRCUMSTANCES OF THE DEATH** Roy Morris was found deceased in Birch Wood off the A40 between Gerrards Cross and Beaconsfield on 30th June 2019. It is probable that Roy hanged himself in the wood on the night of 26th/27th May 2019. He was last seen in the vicinity shortly after 7pm on the 26th May 2019 and there was no further contact subsequently. At the time of his death, Roy was under the care of the local community mental health team and had been attending the acute day hospital having been discharged from inpatient care on 17th May 2019. When Roy was discharged to the community mental health team, he did not have a detailed written care plan in place. During the period of Roy's stay as an inpatient Roy's family were not provided with the means to engage fully and candidly with the inpatient team about their experiences of how Roy was presenting to them. A care coordinator, whose role is central to the coordination of care between the patient, his family and the mental health teams, was only allocated to Roy shortly before he was discharged.
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. The application of the CPA policy for patients such as Roy so that they will have a detailed care plan with which they can engage and which informs the family, the care coordinator and the community team on discharge from the inpatient setting. 2. Reinforcing the importance of the role of care coordinator and ensuring the timely allocation to inpatients shortly after admission so that they can work over a meaningful period with the patient, the family and the mental health teams in anticipation of the discharge into the community.

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6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 24th May 2021. 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: The Family of Roy Morris Frimley Health NHS Foundation Trust Care Quality Commission 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	**29th March 2021** **Crispin Giles Butler, Senior Coroner for Buckinghamshire**