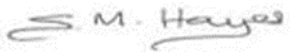
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive of Oxford Health NHS Trust**
1	**CORONER** I am Sonia Hayes assistant coroner for the coroner area of Oxfordshire
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 16 March 2020 an investigation was commenced into the death of LISA MARIE THOMPSON . The investigation concluded at the end of the inquest on 19th November 2020 . The conclusion of the inquest was Suicide. The medical cause of death was Ia Hypoxic Brain Injury, Ib Cardio Respiratory Arrest, Ic Asphyxiation , II Depression
4	**CIRCUMSTANCES OF THE DEATH** Lisa was found unresponsive at home at approximately 10:30 on 14th March 2020 having tied a ligature around her neck and attaching this to the spindle of the staircase with the intention of ending her life. She was resuscitated and conveyed to the John Radcliffe Hospital where she died of an Hypoxic Brain Injury due to cardiorespiratory arrest caused by asphyxiation. Lisa had taken significant overdoses of her prescribed medication for severe anxiety and depression in December 2019 and January, February and March 2020 each time minimizing her actions despite apparent escalation of her behaviour, assurances each time this was impulsive and, she would not do it again. She was sensitive to the side effects of medication and reported no beneficial effects. She was known to be in crisis during this period and was prescribed diazepam on 10th March and reviewed by a new psychiatrist on 13th March. Her explanations of her overdoses were not consistent with her actions and contained inaccuracies, she was not challenged about this by the mental health team. Her care plan and risk assessments were not up-to-date.

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. – Evidence was heard that: (1) There was no clear care plan in place following an emergency review of Mrs Thompson on 13th March 2020 (2) The care plans and risk assessments at the mental health Trust were not updated: (a) with material information on the facts and circumstances of Mrs Thompson's overdoses of her medication. (b) the two most recent overdoses were not recorded (c) with further information disclosed by the doctor who treated her most recent overdose that Mrs Thompson had lied about the severity of her overdose that it was probably double that which she initially disclosed also that this was her 4th overdose and another could not be ruled out. (d) on 13th March 2020 following a review with the Trust Consultant Psychiatrist (e) on 13th March 2020 when there was a telephone conversation between Mrs Thompson and her care co-ordinator
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 7th April 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 [redacted](husband). I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**10th February 2021** **Signature:**  **Assistant Coroner Oxfordshire**