REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Dr [redacted], Medical Director, Cornwall Partnership (Foundation) Trust**
1	**CORONER** I am Andrew Cox, the Senior Coroner for the coroner area of Cornwall and the Isles of Scilly.
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 14/10/21, I concluded an inquest into the death of Kirsty Marie Doodes who died on 27/3/20. . The medical cause of death was recorded as: [redacted] [redacted] [redacted] I recorded a Conclusion of a death from Suicide.
4	**CIRCUMSTANCES OF THE DEATH** Kirsty was a 37-year-old lady with a long history of mental ill-health and an established diagnosis of an emotionally unstable personality disorder. Following a deterioration in her presentation she was admitted under s2 MHA to Carbis ward, Longreach on 3 March 2020. She attempted to [redacted] on five occasions. On 18 March 2020, an appropriate decision was made to discharge her from section and the ward. This coincided with the national lockdown due to the COVID-19 pandemic. Kirsty deteriorated at home. She was attended upon by mental health staff on 24 March 2020 and informed that she would either require a lengthy detention in a specialist unit or she could try to work with clinicians in a community setting. She opted for the latter. On 27 March 2020, Kirsty [redacted]. She was taken to Derriford Hospital but could not be resuscitated and died from her injuries.
5	**<u>CORONER'S CONCERNS</u>** 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. – i) Insufficiency of note-keeping. ii) The note made by Dr [redacted] in the RiO records was described by an independent expert, Dr [redacted], as extremely brief. I accept that medical notes should not be defensive in nature but there is nothing at all in it to justify the view expressed that Kirsty was safe to

	go home. In a context where she has, over a very recent period, attempted to [redacted] on five occasions, the rationale explaining how it was felt she was safe to go home should, in my view, have been set out. Of perhaps more significance is that there was nothing in the note to assist clinicians with understanding how the future care plan was to be organised. That was in a context where a national lockdown was imminent. Given the unprecedented circumstances, it seems apparent to me that there was all the more reason to provide detail in this regard. The fact it was not set out, it seems to me, implies that there was doubt on the part of Dr [redacted] about how the plan to continue treating Kirsty was to be organised. My fear is that this simply passed the burden of the management of the risk to [redacted]. This reached an entirely foreseeable crisis in the early hours of 23 March. Kirsty had deteriorated to the point she was described as very suicidal. [redacted] was exhausted from his desperate efforts to keep his wife safe. He rang the ward for assistance. There was no one available to help him. [redacted] was advised to call the emergency services. He rang the police who told him to ring the ambulance service who told him to ring the CMHT in the morning. This should not have happened. A detailed plan with how to manage an acute deterioration could have prevented it. At the time, Doctor [redacted] was effectively carrying the burden of two consultant psychiatrists in that Dr [redacted] was away from work. I indicated at inquest that if this was due to under-resourcing of the Trust, I would write to those responsible for funding. I was advised that, in fact, the problem may be due to a scarcity of consultant psychiatrists nationally. I would be grateful if you could please let me know the position. iii) Lack of involvement of family/carer in discharge process The Trust's own discharge policy states: 3. Principles The decision to discharge someone from hospital must be in keeping with the Care Programme Approach (CPA), (DH 1991, 2008) and governed by the following principles: The patient, carer and / or advocate, must be actively involved in all aspects of the discharge plan, where practicable. Arrangements for discharge should be negotiated with everyone likely to be concerned with the service user's aftercare. [redacted] was Kirsty's carer. He had not been 'actively involved in all aspects of the discharge plan.' He had a phone call to come and collect her and on arriving at the hospital he found her bag to be packed. He did not feel as though he was given any choice. I acknowledged at inquest that there were extenuating circumstances in that Kirsty's discharge coincided with the first national lockdown during the COVID pandemic. Nevertheless, I think it is appropriate to bring to your attention whether there is a need to remind clinicians to involve families and carers in a meaningful way during the discharge process.
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 10/12/21. 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,) [redacted] (mother) and [redacted] (daughter.) 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] 14.10.21** **[SIGNED BY CORONER]**