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.** [redacted], Chief Executive of Dorset Council **2.** [redacted], Chief Constable of Dorset Police
1	**CORONER** I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset
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 the 20th May 2020, an investigation was commenced into the death of Carol Patricia Cole, born on the 21st November 1951. The investigation concluded at the end of the Inquest on the 21st January 2022. The Medical Cause of Death was: Ia Combined overdose [redacted] II Ischaemic Heart Disease The conclusion of the Inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** On the 15th May 2020 the deceased, who was prescribed [redacted] and [redacted] medication, and who had a history of depression, unstable personality disorder and previous overdoses of medication, was found in a collapsed and unresponsive condition in the bedroom at her home address at [redacted], Weymouth.
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. During the inquest evidence was heard that:

    i. Following attendances upon Mrs Cole by officers from Dorset Police in the days and weeks leading up to her death, two Public Protection Notice (PPN) were submitted to the Multi Agency Safeguarding Hub (MASH) within Dorset Police. The first of these PPNs raised concerns about Carole's mental health.

    ii. When a PPN is received by the team within MASH, they forward the PPN onto the relevant agencies, or people, who can provide support to the individual, or take action. One of those to whom this can be shared is the person's General Practitioner (GP).

    iii. In Dorset there are 2 Local Authorities that cover the County, BCP Council and Dorset Council. If MASH receive a PPN about a resident in the BCP Council area the current arrangement is that MASH send the PPN directly to the GP as required. If they receive a PPN about a resident in the Dorset Council area the current process is that they do not send it directly to the GP but send it directly to the Dorset Adult Access team at Dorset Council, who will then send it to the GP.

    iv. At the time of her death Carole resided within the Dorset Council area. A PPN was submitted to MASH regarding Carole on 25.4.20 which raised concerns regarding her mental health. The MASH team determined the PNN should be shared with the Dorset Adult Access team to share with the GP in line with the process.

    v. At the Inquest the representative from the GP surgery confirmed there was no record of the PNN being received by them, which led to a missed opportunity for Carole to be assessed by her GP.

    vi. The process currently in place, which I understand has been agreed by both Dorset Council and Dorset Police, of preventing the MASH team from sending the PNN directly to the GP, may result in the GP not being informed of the contents of the PPN which may result in a person not receiving an assessment, support or treatment. I am not aware of a reason why the MASH team cannot send it directly to the GP, as they do for those residents in BCP council area, to avoid such missed opportunities to take action which may lead to a future death.

2. I have concerns with regard to the following:

    i. There could be missed opportunities to share PPNs relating to residents within the Dorset Council area with agencies or professionals due to the current processes in place between Dorset Police and Dorset Council which could lead to a future death. I therefore request that Dorset Police and Dorset Council review their current processes in place regarding the sharing of PPNs by MASH, especially to General Practitioners for the residents within the Dorset Council area.

6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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, 30th March 2022. 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) Mrs Clough's family (2) Dorset County Hospital NHS Foundation Trust 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	**Dated** **2nd February 2022**	**Signed**  **Rachael C Griffin**