	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Chief Executive Officer of Devon Partnership NHS Trust**
1	**CORONER** I am Ian Michael Arrow, Senior Coroner for Plymouth Torbay and South 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** Following an Inquest opened on 3 April 2020 and a hearing on 9 October 2020 in the HM Coroner's Court, Plymouth I found that Benjamin Popavach had died as a result of:- 1(a) Drowning
4	**CIRCUMSTANCES OF THE DEATH** The deceased was on home leave from a mental health unit where he was a voluntary patient. He could not be contacted by medical staff and his body was subsequently found in the sea off Corbyn Head, Torquay. The Coroner recorded an Open conclusion.
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) The Coroner has seen a copy of the Root Cause Analysis dated 27 March 2020. Your reference number RMS: [redacted] author [redacted] (2) At Page 20 of the Root Cause Analysis there is an outcome of the review listed under **Immediate Changes** – Ensure risk assessments are completed for patients going on leave, which identify risks in the community and agreed actions to be taken by staff in case of a breakdown in plan **Sharing the learning** - To be shared with Ward Staff and Community Teams

6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe you have the power to take such action to put those recommendations into effect. I should be obliged if you would confirm that action has been taken to put those recommendations into effect.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 15 December 2020. 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. 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 23.10.20 Signature_____