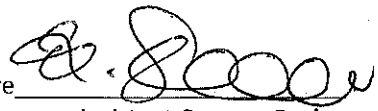
Derby & Derbyshire Coroner's Area

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. The Family of Mr David Ball; 2. NHS England; 3. NHS Digital; and 4. The Chief Coroner
1	**CORONER** I am Emma Serrano, Assistant Coroner for Derby and Derbyshire Coroners Area
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 3 July 2018 I commenced an investigation into the death of David BALL. The investigation concluded at the end of the inquest 18th April 2018. The conclusion of the inquest was a suicide conclusion as follows: "Suicide contributed to by a discharge care plan, put in place on his discharge from an informal inpatient stay on the Hartington Unit on the 1 June 2018, not being fully implemented by the community mental health teams" The medical cause of death was 1a) Methadone and Venlafaxine misuse
4	**CIRCUMSTANCES OF THE DEATH** 1. Between the 12 March 2019 and the 1 June 2019 David Ball was a voluntary patient at the Hartington Unit, which is a mental health unit. This was due to an extensive mental health history including suicide by overdose attempts. David Ball had a history of depression, paranoia, delusions and hallucinations. In addition, he had a history of drugs misuse. He had a past history of deliberate overdose attempts when distressed and suffering from delusions. 2. On the 1 June 2019 he was deemed fit for discharge. His discharge care plan dictated that he was allocated a Community Psychiatric Nurse, he was visited by a Social Worker 3 times per day and he wold be supported by the Community. 3. He did not receive a Community Psychiatric Nurse, he received 3 social worker visits per day until the 4 June, and he has support of the Community Mental Health Team. He was admitted to Chesterfield Royal Hospital from the 4 June 2019 to the 17 June 2019. This was for unrelated matters. From the 4 June, to the date of his passing on the 30 June 2019 his discharge care plan was not carried out. 4. The issues identified at inquest were firstly, the assumption that a Community Psychiatric Nurse would be allocated to David Ball. This was incorrect and would be subject to a decision making

	process. The outcome of which was that he was not allocated one. Secondly, there was assumed communication with the sending of an email, with no process for ascertaining that it was received or actioned. Finally, different health care departments have different patient care records and the departments did not communicate with one another. Evidence was heard that healthcare professionals would have to rely on professional curiosity to ascertain crucial information regarding their patients. 5. It was accepted that David Ball did not get the help and support envisaged when the Discharge Care Plan from the Hartington Unit was drafted. 6. On the 30 June 2019 David Ball was found deceased at his home address having taken amounts of methadone and venlafaxine not compatible with life. He did so with the intention of taking his own life after delusions and paranoia presented.
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. Evidence emerged during the inquest of two areas of concern: Different health care departments have different patient care records and the departments did not communicate with one another. Evidence was heard that healthcare professionals would have to rely on professional curiosity to ascertain crucial information regarding their patients. The examples used within the Inquest of David Ball were that the Hospital, Social Care and Derbyshire Healthcare all had different patient care records.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 12 January 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: 1. The Family of Mr David Ball; 2. NHS England; and 3. NHS Digital. 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	24 November 2020 Signature  Emma Serrano Assistant Coroner **Derby and Derbyshire Coroners Area**