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:

Dr. Hayley Richards
 Chief Executive
 Avon & Wiltshire Mental Health Partnership NHS Trust
 Jenner House
 Langley Park Estate
 Chippenham
 SN15 1GG

CORONER

I am Robert Sowersby, Assistant Coroner, for the Area of Avon.

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 16th February 2016 an investigation commenced into the death of **John Gerard JONES**, Aged **57**.

The investigation concluded at the end of the inquest on 1st August 2016. The conclusion of the inquest was that the medical cause of death was

la Drowning

And the conclusion was Suicide

4 CIRCUMSTANCES OF THE DEATH

Mr. Jones had been receiving support because of his perceived risk of suicide from late December 2015. On 2 January 2016 he was assessed and admission to hospital was recommended by approved psychiatrists, but the decision was taken not to admit him. On 13 January 2016 he was discharged from further support and on or around 1 February 2016 he took his own life by drowning himself in the River Avon.

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) Mr Jones was initially referred to the Crisis Team because his GP believed that Mr Jones' suicide risk could not be safely managed within the community.
- (2) When Mr Jones was in due course discharged from the Crisis Team's care it was approximately a week before his GP was notified of that discharge. That notification was received by fax.
- (3) This meant that during the important period immediately after discharge from the Crisis Team's care there was a period of approximately a week when Mr Jones was (notionally) back under the care of his GP, but his GP was unaware that this was the case: this meant that Mr Jones would have had no support within the community during this period aside from a single follow up / post-discharge call from the Crisis team.

 (4) In evidence the GP indicated that it would have been helpful to have been contacted

by telephone at the time of Mr Jones' discharge and notified of it.

9	05 September 2016 R. Sowersby
	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.
	I am also under a duty to send the Chief Coroner a copy of your response.
	I have sent a copy of my report to the Chief Coroner and to the following Interested Persons – the family and South Gloucestershire Council, as well as the Care Quality Commission.
8	COPIES and PUBLICATION
	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.
	You are under a duty to respond to this report within 56 days of the date of this report, namely by 31 October 2016. I, the Coroner, may extend the period.
7	YOUR RESPONSE
	In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
3	ACTION SHOULD BE TAKEN
	(5) It did not appear to me that there was any clear provision within the Crisis Team's training / structure / protocols for the sort of communication envisaged by Mr Jones' GP.