ANNEX A

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. Mr P Confue, Chief Executive Cornwall Partnership Foundation Trust, Fairview House, Corporation Road, Bodmin, Cornwall PL31 1FB.**
1	**CORONER** I am Andrew Cox, Her Majesty's Assistant 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 4 November 2015, an inquest was commenced into the death of Danny Sweet. The inquest concluded at a hearing on 21 July 2016. The medical cause of death was found to be: Ia Fulminant hepatic failure; Ib Paracetamol overdose. I returned an open conclusion. While I felt it was highly likely that Mr Sweet had taken his own life and intended to do so, I could not be sure of this.

4	**CIRCUMSTANCES OF THE DEATH** Mr Sweet had a long history of mental health issues extending back nearly 20 years. On 15 September 2015 he was seen in the Emergency Department at Royal Cornwall Hospital Truro following a suspected overdose. He was seen by [redacted] a Consultant Psychiatrist, who considered whether Mr Sweet should have a Mental Health Act assessment. [redacted] concluded that there were no grounds to detain Mr Sweet compulsorily. He considered whether a voluntary admission was appropriate, but instead chose to refer Mr Sweet to the Home Treatment Team. Mr Sweet was seen the next day by the Home Treatment Team and I heard evidence from [redacted] who saw Mr Sweet with a colleague. Notwithstanding the Consultant's misgivings the day before, [redacted] found Mr Sweet to be much improved. He felt there was no need for involvement by the HTT and elected to refer Mr Sweet to the Community Mental Health team. Mr Sweet was subsequently seen by [redacted] on 16 October, that is to say, one month after the assessment by [redacted] Mr Sweet told [redacted] he was much improved and did not need any input from CMHT. Accordingly, [redacted] discharged him from the caseload. Subsequently, Mr Sweet told an out of hours worker that he had misled [redacted] and that, in fact, his true condition was worse than he had led her to believe. A duty worker subsequently contacted Mr Sweet who, yet again, gave a contrary indication and said that he did not require any assistance. On 23 October (one week after discharge from the CMHT workload) Mr Sweet took a staggered overdose of paracetamol and died the next day in Treliske hospital.

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: Mr Sweet presented in equivocal and contradictory fashion. Accordingly, he was very difficult to assess and it was equally difficult for clinicians to form a view of the likely risk he posed to himself. I was concerned, however, that the very day after a Consultant Psychiatrist contemplated informal admission into hospital, a nurse from the HTT felt able to refer Mr Sweet to the Community Mental Health team where he was not seen for a month. I wondered if it may be appropriate to reflect on how to deal with patients who present in an inconsistent manner. In particular, I questioned whether it was appropriate simply to presume the best case scenario. I was further concerned whether or not it was appropriate for a check to be built into the assessment process to ensure consistency in treatment decisions. There appeared to be obvious inconsistencies first in the concern of [redacted] and the decision the very next day to discharge Mr Sweet from the caseload of the HTT and secondly, in the decision of [redacted] to refer to CMHT yet [redacted] discharging Mr Sweet from caseload after a first assessment. Mr Sweet's case raises a more general issue namely, how the Trust deals with patients (within the confines of the Law as currently drawn) who appear to have capacity and yet decline treatment/care even where family/friends state their condition is deteriorating. I recognise this is a difficult issue. I wonder, however, whether in such situations, clinicians should record in the notes and records their concerns that patients have capacity and yet may go on to self-harm. Furthermore, I feel it may be worth reviewing if clinicians should share those concerns with family/friends who try and bring to attention the patient's deteriorating condition. I recognise there will be an obvious need to respect the rules on confidentiality. I raise also whether there should be training to ensure that the entries in the notes and records are consistent. By way of illustration, where [redacted] and [redacted] decide to discharge Mr Sweet from their respective caseloads, they should justify those decisions in light of [redacted] s earlier concern that Mr Sweet may need an informal admission into hospital. A final matter that came out of the inquest was that the Serious Incident Report was incomplete. In particular, neither [redacted] nor [redacted] had been formally interviewed as part of the review process. You may feel that there would be merit in getting the respective clinicians from the relevant departments (Hospital Liaison, HTT and CMHT) together to see if there are any lessons to be learned.
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 23 September 2016. 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] and to [redacted] Solicitor Cornwall Partnership 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 Assistant Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**[DATE]** 29/07/16 **[SIGNED BY CORONER]** pp. K J Thirgwin **29 July 2016** **A J COX**