REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The Chief Executive** **NHS Northern Eastern and Western Clinical Commissioning Group** **Newcourt House** **Newcourt Drive** **Old Rydon Lane** **Exeter** **Devon** **EX2 7JQ** 2. **The Chief Executive** **Ministerial Correspondence and Public Enquiries Unit** **Department of Health** **Richmond House** **79 Whitehall** **London** **SW1A 2NS** 3. **Melanie Walker** **Chief Executive** **Devon Partnership Trust** **Wonford House Hospital** **Dryden Road** **Wonford** **Exeter** **Devon** **EX2 5AF**
1	**CORONER** I am Mrs Lydia Brown, Assistant Coroner for the Exeter and Great Devon District
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 2nd July 2014 I commenced an investigation into the death of Louise Turner otherwise known as Abigail Jessica Jackson. The investigation concluded at the end of the Inquest on 16 May 2016. The conclusion of the Inquest was: Medical cause of death 1(a) Helium Asphyxiation Conclusion – Suicide contributed to by neglect

4	**CIRCUMSTANCES OF THE DEATH** Louise died on 27 June 2014 from inhalation of helium at 29 Gabriel Court, Commercial Road, Exeter. At the time she was receiving ongoing treatment for a serious mental health illness and had recently been discharged home after a lengthy in-patient stay. It had been agreed by Louise that the hospital would take custody of and destroy the helium she had obtained, but as there were no effective plans or policies in place, instead it was returned to her the day before she died. The clinicians responsible for Louise's care were fully aware of the potential psychological impact this would have and her previous high risk, self- harming behaviour patterns. Furthermore, Louise's feelings of abandonment were increased as no physical care arrangements were in place due to poor communication and the promised mental health contacts were not conducted in accordance with the care plan and her needs.
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 Devon Partnership trust had no adequate mental health care for Louise after she was discharged. There was inadequate contact and no explanation at Inquest as to why this had not taken place. (2) The duty system arrangements and buddying system referred to at Inquest were not effective or robust and need to be reconsidered in the light of the outcome of this case. (3) There was a suggestion at Inquest that the patients themselves were expected to be in charge of making contact. In cases of severe mental health, this does not appear to be appropriate or realistic, and the Devon Partnership Trust should reconsider this and/or the training of their staff who hold this belief. (4) There are no female intensive care beds for psychiatric patients in Devon. This does not match the desired parity of mental health care with physical health care. Devon Partnership Trust needs to consider future planning and provision to ensure the needs of patients can be met.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 2 November 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.

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8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: (Mother of Deceased) (Devon Partnership Trust) (Devon Partnership Trust) (Bond Dickinson) (Adult Social Care) (Principal Social Worker) (Trust Solicitor – RD&E Exeter) 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	**Date** 7. September 2016 **Signed** .... **Lydia C. Brown** **H. M. Assistant Coroner for Exeter and Greater Devon** **Room 226** **County Hall** **Topsham Road** **EXETER** **Devon EX2 4QD**