*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], Chief Medical Officer, CIOS ICB 2. Rt Hon V Atkins MP, Secretary of State for Health & Social Care
1	**CORONER** I am Andrew Cox, the Senior 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 8 May, I concluded the inquest into the death of Sally Poynton who was stabbed to death by her son on 22 June 2021. I recorded the cause of death as 1a) Knife wounds to neck and abdomen I returned the following narrative conclusion. Sally Poynton was unlawfully killed. Had referrals for medical re-assessment of her assailant been accepted or a needs assessment conducted, on the evidence, it is more likely than not that the assailant's deteriorating mental health would have been identified, a treatment plan instituted, and Sally would not have died when she did.
4	**CIRCUMSTANCES OF THE DEATH** This was a long and complex inquest involving multiple State agencies. I enclose a copy of my written judgment. In summary, my overview of the background to the case was as follows: 1) Sally was just 44 years of age when she was fatally stabbed on 22 June 2021. What compounds this tragedy is that it was her son [redacted] who was her assailant when Sally had known he was unwell for some considerable time and had been trying to obtain help for him. At [redacted] subsequent criminal trial, he was diagnosed by two psychiatrists with schizophrenia. He was

	charged with murder but, given his diagnosis, the Crown accepted a plea of guilty to manslaughter on the grounds of diminished responsibility. [redacted] has been made the subject of a hospital order pursuant to s37 MHA with a s41 restriction. He did not attend the inquest. 2) [redacted] mental health difficulties were known. Indeed, as we shall hear, in June 2020, a year before Sally's death, he had been detained under s2 of the MHA and spent 10 days or so as an in-patient at Longreach Hospital. After his discharge, [redacted] was recognised by various members of his family, particularly Sally, to deteriorate still further. She tried repeatedly to persuade State agencies to help her son. The NHS England report (the Niche report) documents 23 specific requests to four different agencies from Sally for [redacted] to be seen and have his mental health assessed and ten occasions when other family members requested help. Yet, at the time of her death, as a matter of fact, [redacted] was not under the care of CPFT and had not been assessed by a doctor from the Trust for a year. Additionally, there had been four alerts to safeguarding but in the 13 months where [redacted] was known to Adult Social Care, no one had actually seen him, face-to-face. 3) This inquest has been concerned to understand how Sally could have died in these circumstances. In addition to my written judgment, you may wish also to consider the independent NHS mental health review (the Niche report) and the forthcoming DHR, a final draft of which was made available to the Interested Persons.
5	**CORONER'S CONCERNS** During the course of these inquests, the evidence has 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) Mental Health a) In-patient care at Longreach Hospital Approximately one year before Sally's homicide, [redacted] had been detained under s2 of the MHA and spent 10 days at Longreach. At the time, there had been noted changes in his behaviour to include a belief that he could live without food for 10 years (Breatharianism), disinhibited

behaviour to include sunbathing naked on a driveway (believing he received energy from the sun) and a stated belief that others could hear his thoughts – thought broadcasting – a potential symptom of schizophrenia. [redacted] was electively mute, fasting and drinking only distilled water.

He was assessed on at least three occasions by a consultant psychiatrist, was reviewed by multiple junior medical doctors, seen by mental health nurses and reviewed by the Early Intervention in Psychosis Team. No one saw any evidence of psychosis and it was felt there were no longer grounds in law to detain him. He was discharged without a diagnosis or a plan for future care.

At inquest, [redacted] accepted the medical team never completely got to the bottom of the reason for his presentation. His Responsible Clinician, [redacted], referred to a 'quandary' in identifying how much of [redacted] presentation was due to culture or lifestyle and how much was due to his morbid condition. This uncertainty was not reflected in the discharge summary which described [redacted] as a 'model patient.'

One of the most striking features of the evidence was the difficulty Sally then encountered in having [redacted] re-assessed. Indeed, in the year that followed, despite multiple attempts, [redacted] was not seen again by a doctor from the mental health team. It is noteworthy that [redacted] did not believe himself to be unwell, there appears to have been an assumption he had capacity and as he did not consent to treatment, that appears to have become an insurmountable barrier to further care.

I felt there were a number of points of learning:

i) An inaccurate or incomplete discharge summary that did not reflect the element of uncertainty in diagnosis both doctors outlined at inquest;

ii) A failure to discuss with Sally or the maternal side of [redacted] family how he presented, notwithstanding a clear direction following a first ward round to 'collaborate' with the family. This seems particularly relevant given Jacob's mutism which made obtaining a history difficult.
It may be of note that there was a difficult family dynamic with an acrimonious separation of [redacted] parents. [redacted] father was spoken to and there was a reference in the evidence that a member of the in-patient team felt it was Sally's mental health that needed consideration. It was not explored at inquest whether one side of the family's views had been accepted at the expense of the other's.

iii) The absence of a plan detailing the route back for [redacted] to be seen again if the reason for his bizarre presentation was due to an emerging illness (that worsened) rather than alternative lifestyle choices;

iv) A failure to advise Sally, as Nearest Relative, of her statutory right to request [redacted] assessment under the MHA. This omission has been noted previously in other PSIF/SIRs. You may wish to reflect whether information in this regard can be included on a website or similar if it is not already and whether there is a need for training of staff in this regard.

v) A delay of five months in putting into the RiO records a detailed timeline provided by Sally while [redacted] was an in-patient. [redacted] accepted that had he seen it at the time, he would have had further questions for Jacob.

vi) A lack of understanding or professional curiosity about [redacted] drug-taking and the extent to which, if at all, this contributed to [redacted] presentation. It was accepted by [redacted] that he had been misled by [redacted] who had minimised his history in this regard where there was substantial evidence of illicit drug use, including psychotropics.

2) Community Mental Health Team

i) There was a delay of one month in responding to a letter requesting advice from a GP. This was said to be due to staff shortages. At inquest it was noted that, 3.5 years later, staff shortages remain.
I am aware the ICB has made concerted efforts to recruit. This is a concern that appears to require attention from central government and so this point needs addressing by the Secretary of State. I note this is not the first occasion I have written to the Minister to make her aware of the persisting difficulties in recruiting mental health staff in Cornwall and the Isles of Scilly.

ii) A letter requesting advice was treated as a referral (twice.) It was accepted in evidence that there appeared to be confusion on the part of CMHT staff about how to treat a letter from a GP notwithstanding it set out clearly it was a request for advice.

iii) Once the letter from the GP was taken as a request for a referral, attempting to contact the patient by telephone. It was known Jacob was electively mute and so it should have been readily apparent he was not going to respond. Policy appears to have been followed without consideration of the clinical circumstances.

iv) Discharging a patient's referral without any clinical judgment. [redacted] referral was discharged after he did not answer his phone twice (as he wouldn't, being mute) or respond to an opt-in letter (that was sent to the wrong address.) The evidence was clear that [redacted] lacked insight into his condition and steadfastly refused all offers of support. He was not going to 'opt-in' voluntarily. What appeared from the evidence to be a blanket policy of discharging patients who fail to respond (because they are unwell and lack insight) will result in those patients most in need of care being wrongly discharged. In my view, there needs to be some form of triage or clinical attention given to why a patient has not responded and whether it is appropriate to discharge.
I recognise that this consideration, in addition to informing Nearest Relatives of their right to request a MHAA, will result in additional burdens for what is an already over-stretched

	workforce. This may be a matter for the Minister to reflect upon in considering the staffing issue highlighted above. Primary Care There was an accepted lack in continuity in [redacted] primary care after he moved from Sally's address (and a GP in Marazion) to his father's house in Ponsanooth (and a GP in Penryn.) The inquest was told that there are now regular Multi Agency Safeguarding Hubs (MASH) where patients who may be known to both the mental health service and adult safeguarding are discussed. It struck me that there may be value in someone from the ICB attending MASH meetings on behalf of GPs in Cornwall. That individual could then feed back information to the surgery where a patient was registered. In this instance, that would have provided [redacted] with the 'backstory' she did not have, not being in receipt of [redacted] records or the discharge summary from Longreach when she saw him and given the difficulties associated with taking a history from Jacob when he was mute. I wonder if you feel an initiative in this regard would be sensible?
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 11 July. 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: - Sally's family; - [redacted]; - [redacted]; - Penryn Surgery; - Cornwall Council 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]** **[SIGNED BY CORONER]**  **14/5/24**