Central and South East Kent Coroners

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Ms Helen Greatorex, Chief Executive, Kent and Medway NHS and Social Care Partnership Trust.**
1	**CORONER** I am Chris Morris Assistant Coroner for **Central and South East Kent**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 16th December 2016, Patricia Harding, acting senior coroner for Central and South East Kent commenced an investigation into the death of Mr Jamie Fairclough, who was aged 26 when he was found to have died on 9th December 2016. The investigation concluded at the end of the inquest which I heard on 11th April 2017. The conclusion of the inquest was that Mr Fairclough was found dead on 9th December 2016 at his home address from the effects of chemical asphyxiation. At the end of the inquest, I recorded a conclusion of suicide.
4	**CIRCUMSTANCES OF THE DEATH** Mr Fairclough had resided in a variety of supported living environments across the county since around 2010. He lived his life with a variety of complex difficulties, including autism, pervasive developmental disorder and anxiety. From approximately October 2011, Mr Fairclough was provided with services by the Trust's Early Intervention in Psychosis team, which generally works with young adults for a period of around 3 years. In May 2016, a decision was made to transfer Mr Fairclough's care to the Shepway Community Mental Health Team ('CMHT'), with an experienced male Registered Mental Nurse identified as Care Co-ordinator. On 28th June 2016, Mr Fairclough attended a meeting at the CMHT's base, together with his mother, a representative of the Early Intervention in Psychosis team, representatives of Sanctuary Housing Association and the Care Co-ordinator. At this meeting, a plan was agreed whereby the Care Co-ordinator would seek to engage with Mr Fairclough on a fortnightly basis. In view of the fact that it had previously been noted that Mr Fairclough was often reluctant to engage with male professionals, it was agreed to review care co-ordination arrangements in the event Mr Fairclough did not engage with the identified Care Co-ordinator. Mr Fairclough did not attend the first identified appointment on 4th July 2016 which was due to take place at the CMHT's base. Notwithstanding the planned approach of fortnightly engagement, the next

	appointment with Mr Fairclough was scheduled until 12th October 2016, when the Care Co-ordinator attempted to visit him at home. On this occasion, Mr Fairclough refused to answer his door to the Care Co-ordinator. A further home visit was attempted on 18th October 2016, when Mr Fairclough did not appear to be at home. A visit on 20th October 2016 was similarly unsuccessful. On 1st November 2016, the Care Co-ordinator wrote to Mr Fairclough, offering a further appointment at home on 4th November 2016 at his home. The letter went on to state '*I have recently attempted to see you 3 times but have been unsuccessful in meeting up with you. Should you not attend the above meeting then I will have to consider whether support from the Community Mental Health Team is appropriate for you at this time*'. Mr Fairclough did not attend the meeting arranged for 4th November 2016, and on 16th November 2016, he was discharged from the CMHT's caseload. The decision to discharge Mr Fairclough was made: 1) Contrary to the plan arrived at during the meeting which took place on 28th June 2016, when it was agreed to review Care Co-ordination arrangements in the event the identified arrangements were not working; and 2) In the absence of a Care Programme Approach meeting, or any other meaningful dialogue with those who knew Mr Fairclough best. Mr Fairclough was found dead in his flat on 9th December 2016.
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. – In the course of the inquest, I heard evidence that the Care Co-ordinator identified in this case had an allocated case-load of around 75 – 80 service-users. Whilst I heard evidence that the Trust has plans in place to reduce the case-loads of Care co-ordinators by August 2017, case-loads currently remain at similar levels to those which pertained when Mr Fairclough was under the care of the CMHT, notwithstanding the findings of the Trust's own investigation into this case. Indeed, an operational manager who also gave evidence at the inquest confirmed that her current case-load was 86, in addition to managerial responsibilities.

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 7th June 2017. 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) [redacted] 2) [redacted] Solicitor – Kent and Medway NHS and Social Care Partnership Trust) 3) [redacted] (WLG Gowling LLP – Solicitors to the Sanctuary group) . I have also sent it to the Care Quality Commission who may find it useful or of interest. 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	12/04/2017 Signature:  Chris Morris Assistant Coroner **Central and South East Kent**