REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **BRITISH TELECOM ("BT") of BT Group plc, BT Centre, 81 Newgate Street, London EC1A 7AJ** 2. **HAMPSHIRE CONSTABULARY** 3. **SOUTH CENTRAL AMBULANCE SERVICE**
1	**CORONER** I am SAMANTHA MARSH, Acting Area Coroner the coroner area of Hampshire
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 23rd April 2019 I commenced an investigation into the death of William James Moody, aged 85. The investigation concluded at the end of the inquest on 16th September 2019. The conclusion of the inquest was that Mr Moody had died as a result of Suicide (by entering the River Itchen via the banks of his home address on the 19th April 2019). The medical cause of his death was given as drowning.
4	**CIRCUMSTANCES OF THE DEATH** On the 18th April 2019, Mr Moody drove himself from his home in Bishopstoke to Wimbourne and, once there, called his family to express his intention to end his life. He was intercepted by the Police who detained him under Section 136 of the Mental Health Act 1996 and took him to a place of safety (St Ann's Hospital in Poole) where he was the subject of an assessment by a consultant psychiatrist. He was not deemed to be detainable and so was released. On the following day, the 19th April 2019, Mr Moody entered the banks of the River Itchen. The River runs through the gardens/grounds of the Estate on which Mr Moody lived in a cottage. He intentionally entered the River to end his life. He was taken by paramedics to Southampton General Hospital where it was not possible to revive him.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – At Mr Moody's Inquest I heard that his family (who were present throughout events as his daughter and son-in-law own the Estate in which Mr and [redacted]ad a cottage) initially called 999 and asked for the Police to attend. The 999 call-taker triaged the call

	as requiring the attendance of Ambulance Service and deemed this to be a matter that the Police would not attend. This resulted in the family having to redial 999 and ask for an alternative service; during which some level of screening questions were repeated. This caused delay in the family reaching an appropriate service to attend. I heard evidence from the Mental Health Lead for Hampshire Constabulary who explained that as the incident on the 19th April 2019 was occurring in the person's home and, as such the Police have no power to intervene where a person is in their *own home* and in mental health crisis and/or threatening to harm *themselves*. The situation on the 19th of April was distinguished from that which had happened the day before, on the 18th April, as the incident on the 18th had occurred in a *public place* and so, in that case, the police had a duty to attend. I heard further evidence that there is a Memorandum of Understanding ("MOU") between Hampshire Police and the South Central Ambulance Service as to who is the primary response agency for persons making threats of suicidal ideation. Ultimately, the family were confused as to where help would come from and the call-handler will not transfer the call to a particular route/service unless the caller makes the decision as to which service they need. Despite there being a MOU between the agencies this does not appear to be something that the general public is aware of, and the task of making the general public aware of this is likely to be insurmountable and therefore it remains entirely foreseeable that future delays could occur because callers are unaware of which emergency service is the correct one to request in a situation where a person is suffering a mental health crisis episode and/or expressing suicidal ideation within the boundaries of their home. I heard further evidence regarding the existence of a different triage system, that operates in at least one area/jurisdiction of the country, but this only applies when a caller dials the 111 service; callers are given an option of accessing "Mental Health" services and this allows calls to be triaged through to an appropriately trained team/call-handler who can ask a set of wider diagnostic questions to understand and establish which agency, on the particular facts, should be the primary response service to that individual. In the situation of Mr Moody it transpired that it was actually a mixed response that was required; both the Police and Ambulance services. I am concerned that the current system of dealing with 999 calls in Hampshire gives rise to the potential for opportunities to be missed to triage the emergency call quickly and effectively, and to share information between agencies without the need to repeat the screening progress, and these factors may result in further deaths in the future.
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 20th November 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 [redacted] and [redacted] I have also sent a copy to Inspector Griffiths who is the Mental Health Lead for Hampshire Constabulary at Hampshire Constabulary Mental Health Lead Waterlooville Police Station, Swiss Road, Waterlooville PO7 7FX 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]** 25/09/19 **[SIGNED BY CORONER]**