REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Bassetlaw Clinical Commissioning Group** **2. Mansfield and Ashfield Clinical Commissioning Group** **3. Newark and Sherwood Clinical Commissioning Group** **4. Nottingham North and East Clinical Commissioning Group** **5. Nottingham West Clinical Commissioning Group** **6. Rushcliffe Clinical Commissioning Group** **7. Nottingham City Clinical Commissioning Group**
1	**CORONER** I am Mr. Gordon Clow, Assistant Coroner, for the coroner area of Nottinghamshire
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** An inquest was opened into the death of Patricia Ferguson on the 9th May 2019 and concluded on the 15th August 2019. The conclusion of the inquest was that the death was suicide. Prior to the death Patricia Ferguson had been in receipt of secondary mental health services from her local Community Mental Health Team. The care afforded by the clinicians working with Patricia Ferguson was good. The psychiatrist and community psychiatric nurse working with Patricia Ferguson formed the clinical view that she would benefit from direct work from a clinical psychologist. A clinical psychologist was not, however, available to carry out direct work.
4	**CIRCUMSTANCES OF THE DEATH** Patricia Ferguson suffered significant mental ill health at times. She was admitted as an inpatient on one occasion and on other occasions she received secondary mental healthcare including medication, regular review from a Consultant Psychiatrist and support from Community Psychiatric Nurses. When unwell, Patricia Ferguson would typically be overwhelmed with negative thoughts and emotions on a particular issue. This led to her completed suicide. The clinicians working with Patricia Ferguson considered that the particular type of interventions which can only be undertaken by a clinical psychologist would be of benefit to Patricia Ferguson. The inquest heard evidence from Nottinghamshire Healthcare NHS Trust regarding staff establishment within CMHTs. A clinical psychologist was employed by the CMHT working with Patricia Ferguson but was unable to take on new patients as there was going to be a planned period of extended absence. The inquest heard evidence that clinical psychology was a 'precious resource' within the CMHTs. In terms of clinical psychology posts, the inquest heard that in some CMHTs within Nottinghamshire there is a full time equivalent post and in other teams this may be a shared post, or a less than full-time equivalent post. No teams have more than one clinical psychologist. I was satisfied that Nottinghamshire Healthcare NHS Trust have implemented measures to make the best use of their clinical psychologists by means of a new internal protocol.

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 Joint Commissioning Panel for Mental Health's Guidance for Commissioners of Community Specialist Mental Health Services expresses an expectation that there would be more than one clinical psychologist for each Community Mental Health Team, given that clinical psychologists are referred to in the plural within discussions of an appropriate staff team for CMHTs whereas, for example, consultant psychiatrists are referred to in the singular. (2) CMHTs in Nottingham and Nottinghamshire have a commissioned establishment of, at most, one clinical psychologist per team, with some teams having only a part time clinical psychologist post. This inevitably results in some patients, as here, having no access to clinical psychology when this is clinically indicated, creating an ongoing risk of preventable future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe you have the power to take such action. You should consider whether or not commissioning arrangements for CMHTs represent an appropriate balance of available resources in line with the best available guidance.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 18th June 2020. 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: Patricia Ferguson's next of kin Nottinghamshire Healthcare NHS 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 coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**23rd April 2020** **Mr. Gordon Clow**