Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 **Department of Health and Social Care and Public Health England (as the bodies responsible for the National Poisons Information Service)**
2 **The Royal College of Psychiatrists**

1 CORONER

I am Caroline JONES, Assistant Coroner for the coroner area of Cambridgeshire and Peterborough.

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 16 April 2020, an investigation was commenced into the death of JAMES MICHAEL NOWSHADI aged 23 years. The investigation concluded at the end of the inquest on 23 June 2021. The conclusion of the inquest was:

- James' death was a suicide, caused by him deliberately ingesting [redacted]
- James had a long-standing history of depression for which he was latterly involved with the Cambridgeshire & Peterborough NHS Foundation Mental Health Trust, and had expressed his clear intent to end his own life by taking [redacted] that he had ordered via the internet from Poland. Because he was deemed to have capacity, it was not thought appropriate to inform his family (with whom he lived) of his intentions, even if their intervention could have potentially prevented his death
- There was little knowledge or understanding of the role of [redacted] in suicides by those involved in James' care and insufficient exploration of how James had alighted upon [redacted] as the means by which he proposed to end his life, which meant that there was also inadequate consideration of whether this could be a factor in other patients' suicidal ideation.

4 CIRCUMSTANCES OF THE DEATH

James had a history of depression and low mood. From 2016 onwards, he was in receipt of regular therapy and counselling which seemed to have improved his mental wellbeing but in early 2020, he was referred to mental health services when he began expressing specific plans to end his own life. James was seen by clinicians from various teams where he disclosed further details about his intentions. He did not want information about his plans to be disclosed to his family. James was considered to have capacity to make decisions about his care. Although consideration was given to whether to override his stated wishes and inform his family so that they could help to safeguard him, it was felt that the risk of suicide was insufficiently imminent to warrant breaching his right to confidentiality.

Prior to commencing treatment, James had ordered via the internet a quantity of [redacted],

which he proposed to take at a future date as a means of ending his life. He was open about his plans with those treating him but could not be persuaded to share his thoughts with his family nor dispose of the [redacted]. He agreed to continuing engagement with mental health services and was deemed not to meet the criteria for admission to hospital.

In late March 2020, James had not put into effect his plans and appeared to be looking forward to starting a new job and engaging with new psychological treatment options. On the evening of 31 March 2020, James was found unresponsive in his bedroom at the family home, before he had a seizure. An ambulance was called and paramedics attended and gave him emergency care but he went into cardiac arrest. He was taken to Addenbrooke's hospital where despite further attempts at resuscitation, he was pronounced dead at 01.47 hours on 1 April 2020. Tests on his blood revealed that he had a methaemoglobin level of 90% as a likely consequence of ingesting the [redacted]. It is very unlikely that any further medical intervention could have changed the outcome and the prolonged period in cardiac arrest was thought to be unsurvivable.

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 could occur unless action is taken. In the circumstances, it is my statutory duty to report to you.

The MATTERS OF CONCERNS are as follows:

1. There does not appear to be any national guidance available to psychiatrists and mental health practitioners dealing with possible [redacted] cases. Those involved in James' care made insufficient effort to research or evaluate the potential risks and consequences of James obtaining and using the [redacted] to end his life and any information that was obtained from brief internet searches was not disseminated to colleagues beyond those immediately involved in James' case only. I am concerned that there is a risk of future fatalities if mental health practitioners do not have ready access to timely and up-to-date information about the risks associated with sodium nitrate/nitrite.

2. The family raised concerns about the risks of [redacted] in suicides as part of the Serious Incident Review undertaken by the Trust but this section was omitted from the final report at the direction of the SIR review panel. This meant that there was a missed opportunity for the Trust to reflect on lessons that may properly be learned from James' death, an omission which they now appear to be taking steps to remedy. However, I am concerned that there is a risk of future fatalities at a national level if Mental Health Trusts are not using Serious Incident Reviews and other internal investigations to learn lessons from suicide cases, including about the risks presented by sodium nitrate/nitrite.

3. The inquest heard evidence from a senior Accident & Emergency doctor about the information available from the National Poisons Information Service to emergency departments who encounter patients who have ingested [redacted]. This included information about the potential availability of an antidote, 'methylene blue'. However, there is apparently no national guidance about the appropriate use of the antidote in cases involving cardiac arrest and whether attempts should be made to administer it in such cases. I am concerned that there is a risk of future fatalities if A&E clinicians do not have access to comprehensive and up-to-date information about toxic substances and their possible antidotes to know when – and when not – to administer treatment.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 23 September 202123 September 2021. 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], mother of James Nowshadi
2. The Cambridgeshire & Peterborough NHS Foundation 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.

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Carolinejones

Caroline JONES
Assistant Coroner for
Cambridgeshire and Peterborough
Dated: 29/07/2021