REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

[redacted] **Chief Executive, Sheffield Health and Social Care NHS Foundation Trust**

Copies to

1. Chief Executive, Sheffield CCG
2. [redacted], Director Adult Social Care, Sheffield City Council

1 CORONER

I am Stephen Eccleston, Assistant Coroner for the area of South Yorkshire (West)

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 13th October 2021 I commenced an investigation into the death of Joshua Adey Rennard aged 33. The investigation concluded at the end of the inquest on 18th March 2022. The conclusion of the inquest was:

Ia) Hanging

I reached a conclusion of suicide.

4 CIRCUMSTANCES OF THE DEATH

Joshua hanged himself at his parents' home on 29th September 2021.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

5.1 I received evidence from Ms. Spence and Ms. Pawson of the Mental Health Care Trust as follows.

5.2 Joshua had been known to mental health services (MHS) since about 2018. He was again referred to MHS on 26.06.21 and was made subject to an order for assessment under S2 Mental Health Act 1983 (MHA) on 26.07.21. He was discharged to the Sheffield Home Treatment Team on 11.08.21.

5.3 A mental health nurse, Ms. Spence, was allocated on 31.08.21.

5.4 The view was reached on 18th August 2021 that Joshua's deteriorating mental health and level of risk meant that he should be assessed for detention for assessment under s2 MHA. This was not actioned until 26th August 2021. On that date, a warrant was applied for which contained errors which invalidated it. Nevertheless, Joshua was assessed, and the decision taken that he did not require a section as at that date.

5.5 Joshua hanged himself on 29.09.21.

5.6 My particular concern is the delay between a professional view being reached that Joshua required assessment for S2 detention on 18th August 2022 and the actioning of that decision on 26th August 2021, 8 days later. The evidence was that Joshua was at risk during this period although I did not find that the delay specifically contributed to Joshua's death on 29th September 2021. I am specifically concerned that others might be placed at risk if similar delays arise in the future.

5.7 Further evidence was given that this delay was due to the way that the required Approved Mental Health Professional (AMHP) input was allocated or available. The evidence was that delays of this nature were not unusual and that people with mental illness are at risk during these gaps and delays. I considered that such delays in promptly progressing recommendations for assessments for Section could place people at risk of harm and death.

5.8 I require you to report explaining (1) what action will be taken to prevent the risk of deaths while a person who is recommended for assessment for section is waiting for the assessment to take place and (2) what action will be taken to eliminate such waits for assessment.

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 16th May 2022. 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 family of Joshua and also to The Sheffield CCG and the Director of Adult Social Care for Sheffield Council 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.

Dated: 7.3.22

SIGNED BY
Steve Eccleston, Assistant Coroner for South Yorkshire (West)