REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive Somerset NHS Foundation Trust**
1	**CORONER** I am Richard T Middleton, Assistant Coroner, for the Coroner Area of Dorset
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 the 11th March 2021, an investigation was commenced into the death of Andrew Arden Nixon, born on the 20th April 1963 The investigation concluded at the end of the Inquest on the 31st May 2022. The Medical Cause of Death was: 1a Hanging The conclusion of the Inquest recorded Suicide
-4	**CIRCUMSTANCES OF THE DEATH** **Mr Nixon's mental health deteriorated around October 2020. He was treated by his GP and prescribed anti depressants. Following disclosures relating to self harm his GP made an emergency referral to the Mental Health Team on 11/2/21. Mr Nixon was contacted and assessed by the Home Treatment Team during February 2021 and discharged from that service on 2/3/21. On 3/3/21 Mr Nixon was found suspended by a ligature in wooded grounds in North Dorset.**

5 **CORONER'S CONCERNS**

The **MATTERS OF CONCERN** are as follows:

1. During the inquest evidence was heard that:

   i. Mr Nixon was not known to mental health services prior to February 2021.

   ii. Mr Nixon's [redacted] accompanied him to every appointment he had with the Home Treatment Team. She had never had dealings with the Mental Health Services previously.

   iii. Mr Nixon had given permission to the Mental Health Services to share information with [redacted]. On one occasion it was deemed that a doctor could not impart patient information to Mr Nixon's [redacted] because he wrongly thought he did not have permission from the patient to do so.

   iv. Mr Nixon's [redacted] was unaware that he had disclosed "occasional suicidal thoughts" and was therefore unable to assess the risk of Mr Nixon to himself and accordingly did not take any steps to protect him.

   v. The Care Plan, Escalation Plan, Emergency Plan were not drawn up in writing until after Mr Nixon's death. No paperwork was sent to Mr Nixon (and in turn not seen by his partner) by the Home Treatment Team prior to his death. Mr Nixon's partner was not therefore party to or privy to any risk assessment.

   vi. A Carer's Assessment was considered but thought not appropriate as it was believed that Mr Nixon's [redacted] (who was present at all consultations with the Home Treatment Team) was part of what was seen as "an intelligent and resourceful couple".

   vii. The Trust has a patient information leaflet describing what support and advice can be given to a carer. There is a Carer Assessment tool available.

	2. I have concerns with regard to the following: i. The failure to ensure that family members/carers are fully involved from the outset in the risk assessment process and that they have a full comprehension of steps being taken and/or decisions being made. I believe the Trust should take a more proactive approach. ii. There should be criteria to be applied as to who should be considered for a Carer's Assessment at the earliest appointment with the Home Treatment Team. Such criteria should include whether the patient has given permission to share information; whether the patient and/or the carer have been involved with mental health services previously; whether the carer has been/will be present during consultations; the level of understanding of the carer in relation to steps taken and decisions made and whether they need further help. iii. Such criteria may lead to a full carer's assessment. It is noted that there will always be a delay between assessments and the drawing up of care plans etc which will then be sent out to the patient. By establishing an early process of engaging with carers the medical professionals may build in further protective factors for the patient.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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, 1st August 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 following Interested Persons: (1) [redacted] (2) [redacted], Leigh Day Solicitors (3) [redacted] 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	**Dated 6/6/22**	**Signed** **Richard T Middleton**