Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Humber & N. Yorkshire Health & Care Partnership** **2 NHS England and NHS Improvement**
1	**CORONER** I am John BROADBRIDGE, Assistant Coroner for the coroner area of North Yorkshire and York
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 13 July 2021 I commenced an investigation into the death of Antony Christopher MCLELLAN aged 54 ("Mr McLellan"). The investigation concluded at the end of the inquest commenced part heard 1st February and completed 01 July 2022. The conclusion of the inquest was that Mr McLellan died because of suicide.
4	**CIRCUMSTANCES OF THE DEATH** On 9 July 2021 the deceased was found unresponsive within the garage at his home at [redacted] hanging by a ligature [redacted]. His death was recognised there at 14.19 hours that same afternoon, later indicated as from the effects of that hanging.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) 1 Mr McLellan was diagnosed over 2016/16 as being autistic with a designation of Asperger's Syndrome. He was also diagnosed as experiencing Bipolar Disorder, an attribution he did not accept which he repeatedly asserted to both previous Mental Health care providers and the subsequent Trust clinicians tasked with supporting him at the time of his death, Tees Esk and Wear Valleys NHS Foundation Trust ("TEWV") 2 He insisted his difficulties were linked to his autism and not mental disorder. It was accepted that he experienced autism and that was part of his individuality and that in addition he may have had a mental health disorder. It was accepted that his care and treatment cannot unbundle the two but he should be treated holistically. 3 Assessment and formulation of risks and safety summary did not fully explore the impact of his autism. There was little to suggest that TEWV staff a) considered the higher prevalence of suicide for individuals with a diagnosis of autism and b) that

	Mr McLellan may have communicated his distress and risks information differently to an individual without a diagnosis of autism during his periods of crisis or increased risk and c) made sufficient reasonable adjustments in relation to the impact of his autism. 4 At the time of his death, TEWV had progressed from a low baseline in the Trust's work in North Yorkshire to address perceived underdevelopment in their services for the autistic patient when presenting with a mental health disorder. It had expanded the use of a specialist team (Autism Project Team- "APT") to extend its work into North Yorkshire caseload. The steps taken were incremental and not all staff understood that Team and access to that important resource. It is recognised that improvements would take time and be resource dependent as well however. 5 APT has three specialist and autism dedicated practitioners working exclusively with autism across the whole Trust in both its regions of commissioned care although there are also non-dedicated clinicians with some expertise of autism within TEWV. TEWV does not treat autism in North Yorkshire. 6 TEWV in its recent audit indicates about 17% of the individuals open to TEWV (over 10,000 in number) have an autism marker ie have an ICD-10 diagnosis of autism or experience suspected/confirmed autism or have a referral including being suspected as autistic. 7 There was no direct causation to the suicide found that directly attributed the acts he took to his autism from the evidence. However Mr McLellan's distress and stressors before his death included his feelings that he was not getting what he saw to be the right help and that he would not lose his feelings of helplessness such that he took his own life. The concern is that the very significant number of those open to TEWV with an autism marker has increased and will continue to do so and that the higher prevalence of suicide within that expanding group will lead to higher risk of, and numbers of, autistic individuals dying because of suicide both within TEWV locality but also nationally. Urgent solutions are required to prevent further deaths of autistic individuals especially those with mental health disorder by rapidly improving and expanding provisions for assessment and management of risk of harm to themselves for individuals within the autism spectrum while presenting with a mental health disorder.
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 30 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 [redacted] I have also sent it to the CEO Tees Esk and Wear Valleys NHS Foundation Trust

	who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 05/07/2022** JNBroadbridge **John BROADBRIDGE** **Assistant Coroner for** **North Yorkshire and York**