REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. The Rt Hon Steve Barclay MP, Secretary of State for Health and Social Care 2. South West Yorkshire Partnership NHS Foundation Trust
1	**CORONER** I am Kevin McLoughlin, Senior Coroner for the Coroner area of West Yorkshire (Eastern)
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 3 August 2021 I commenced an investigation into the death of Daniel Clements, aged 27. The investigation concluded at the end of the Inquest on 13 July 2022. A conclusion of suicide was recorded based upon a cause of death of 1a Multiple Injuries.
4	**CIRCUMSTANCES OF THE DEATH** Daniel Clements aged 27 was a troubled young man. On Monday 19 July 2021 he was taken to hospital by the police and underwent a psychiatric assessment that afternoon. He was deemed not to be suffering from a mental illness and was discharged to his GP. At 20:45 hours the same day he ran into the path of a fast-moving train and sustained fatal injuries.
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) How can a person displaying suicidal ideation be kept safe, if deemed not to be mentally ill? (2) Daniel Clements was a troubled young man aged 27. He had a low IQ, little education and was not fully compliant with his prescribed Risperidone medication (used to treat psychotic illness). He had always been dependent upon his mother, but when she was admitted to a care home in February 2021 (during the Coronavirus pandemic) he became homeless and adrift in society. In short, he was a vulnerable young man.

(3) In the fortnight before his death Mr Clements had the following interactions with healthcare professionals:

a) On 6 July 2021 he attended an A&E department and reported a deterioration in his mental health with symptoms of anxiety, inability to sleep, drug debts and homelessness, which were deemed attributable to his social situation rather than mental illness. He was referred back to his GP and advised to contact the police if he became concerned about his own safety. He was considered at that time to have the mental capacity to make choices affecting his social situation.

b) On 8 July 2021 he sought help from his GP and was referred to the Crisis Team (the Intensive Home-Based Treatment Team).

c) On 12 July 2021 his brother contacted the Single Point of Access to voice concerns about his mental state as Mr Clements was phoning him through the night and coming to his home. A representative from the Single Point of Access discussed with the brother options which included seeking an injunction against Mr Clements. He had sought a replacement prescription from his GP but had allegedly been refused an early issue of his medication.

d) On 19 July 2021 Mr Clements was brought by the police to the A&E Department at Pinderfields Hospital who referred him to the Psychiatrist Liaison Team. He was assessed by a registered mental health nurse and a Psychiatric Liaison Practitioner. They concluded he did not present with any symptoms indicative of an acute mental illness. He said in response to a direct question that he was "always suicidal". Mr Clements was advised to collect his medication from the pharmacy, to work with housing, pay some of his drug debts and was given a leaflet outlining the Psychiatric Liaison Team Service.

(4) Mr Clements was passed between agencies without any lasting benefit. This tragic situation illustrates the void in relation to those with suicidal feelings without any overt psychiatric illness.

(5) The Secretary of State for Health and Social Care is asked to consider whether an extension to the Section 136 Mental Health Act 1983 power is required in order that a person such as Mr Clements could be detained for a few days in order to help him through a period of crisis. In this period a multi-disciplinary meeting involving the family, social worker, GP and psychiatric specialist might devise a plan to combat the social problems which otherwise devour the time of healthcare professionals without any conspicuous gain

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and the Trust 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 Monday 5 September 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], Sister 2. [redacted], Brother 3. [redacted] White Rose Surgery 4. British Transport Police, FAO: [redacted] 5. [redacted], South West Yorkshire Partnership 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.
9	 Kevin McLoughlin Senior Coroner West Yorkshire (Eastern) 13th July 2022