	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** • **The Chief Executive, NHS England** • **The Chief Officer, NHS Tees Valley CCG**
1	**CORONER** I am Jo Wharton, HM Assistant Coroner for the coroner area of Teesside & Hartlepool
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 21 June 2019 I commenced an investigation into the death of Dean Ryan CROSSMAN aged 51. The investigation concluded at the end of the inquest held between 24 and 26 May 2022. The conclusion of the inquest was suicide, the medical cause of death being hanging.
4	**CIRCUMSTANCES OF THE DEATH** • On the evening of 17 June 2019, Dean had contacted [redacted] alluding to the fact he was contemplating suicide. When friends arrived, Dean was standing on the landing with a rope tied around his neck. His friends called the NEAS and when paramedics arrived, they spent nearly two hours with Dean trying to encourage him to attend hospital, but Dean refused. Paramedics contacted the Crisis Team (CT) and stayed with Dean until they arrived. • Arriving around 3.15am, the CT were initially with Dean for about 90 minutes. Dean presented to the CT as hopeless and was deemed to be at risk of suicide. Dean refused admission to a psychiatric hospital and was not receptive to the help and intervention offered by the CT. The CT left Dean with his friend who agreed he would stay with Dean until 9.30am, when the CT stated they would return to carry out a full assessment. • The CT then contacted the Emergency Duty Team (EDT) to request a formal MHA assessment in the community. The AMHP who received such request (around 4.20am), did not progress the MHA assessment, perceiving the following to be issues – the fact she was working alone, potential difficulty identifying a second doctor and potential delay securing a timely response from the private ambulance service (ERS Medical), which she thought in itself could significantly increase the risk to her own safety and Dean's safety. Thinking it was unlikely that a MHA assessment would take place before the CT's scheduled 9.30am visit, it was agreed that it be handed to day staff to co-ordinate. • Dean's friend left him around 5.30am and went home. He left Dean sleeping on a chair in the living room, having removed the rope from the loft hatch. Concerned for Dean's immediate safety, the CT called the police. The police attended Dean's home around 6.18am and Dean told them he was not having suicidal thoughts at that time. The police officers removed the rope from Dean's home and stayed with him until the CT arrived around 6.30am. • Upon assessment, the CT thought Dean's presentation had changed and that he was no longer at risk of suicide. It was agreed that the CT would visit Dean again at 9.30am to review his mental state and discuss with Dean how they could best support him. Dean

	said he would engage with them and he was going to have a sleep and then a shower before they returned at 9.30am. The CT left Dean around 6.56am and contacted the EDT to advise that the MHA assessment could be stood down. • When the CT returned at 9.30am on 18 June 2019, sadly Dean was found hanging [redacted]
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: 1. Evidence was given at the inquest that at the time of Dean's passing, there were issues accessing second (s.12) doctors out of office hours for the purpose of carrying out a MHA assessment, resulting in delays to MHA assessments being carried out. The EDT explained that since Dean's passing, a "s.12 Solutions" App has been introduced, and although this had made a significant improvement, issues still exist trying to access a second doctor out of hours, as the EDT is still wholly reliant on second doctors making themselves available after midnight (with no fixed rota). 2. Evidence was given at the inquest that at the time of Dean's passing, there were issues securing the timely attendance of the private ambulance service (ERS Medical) to transport patients after a MHA assessment had taken place, potentially resulting in an increased risk to both the AMHP and the patient for MHA assessments in the community. The EDT advised that since Dean's passing, despite spot purchasing of private ambulances being introduced, issues still exist trying to get the private ambulance to attend a MHA assessment in a timely manner. 3. Evidence was given at the inquest that both of the above matters of concern are on-going national issues.
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 July 21, 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 • **Dean's family** • **The Emergency Duty Team (under the remit of Stockton on Tees Borough Council)** • **The Crisis Team (under the remit of Tees Esk & Wear Valley NHS Foundation Trust)** • **The Chief Constable of Cleveland Police**

	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: 26 May 2022** *J. Wharton* **Jo Wharton** **HM Assistant Coroner for Teesside & Hartlepool**