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 Nottinghamshire Healthcare Trust** **2 Turning Point**
1	**CORONER** I am Gordon CLOW, Assistant Coroner for the coroner area of Nottingham City and Nottinghamshire
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 23 July 2021 I commenced an investigation into the death of Keith Andrew NOTTLE aged 48. The investigation concluded at the end of the inquest on 13 June 2022. The conclusion of the inquest was that Mr Nottle's death was by accident, on the basis of him having taken an overdose as a cry for help, or to secure secondary mental health treatment, but which caused his death.
4	**CIRCUMSTANCES OF THE DEATH** Mr Nottle experienced a protracted period of poor mental health. He was successfully treated for symptoms of psychosis but many other aspects of his complex mental health difficulties were resistant to treatments provided. On or shortly before 5 July 2021 Mr Nottle took an overdose of two of his prescribed medications. He was discovered by emergency services to be extremely unwell and conveyed to hospital. Despite all appropriate treatment being afforded, Mr Nottle died on 5 July 2021 from the effects of the overdose of medication. Mr Nottle's mental health and wellbeing had deteriorated in the period leading up to his death. He was experiencing symptoms which may have been the early signs of a relapse into psychosis. He had been upset with the decision to discharge him from the local mental health team at the time that he returned to independent living, a decision upon which he had not been consulted and which had not been communicated directly to him. Both Mr Nottle's family and a number of other agencies sought to secure the re-engagement of the local mental health team in the months that followed. All referrals were refused. Mr Nottle's GP was not provided with details of Mr Nottle's diagnosis, advice as to how to manage Mr Nottle's psychiatric medications, or of circumstances in which Mr Nottle should be referred back to the local mental health team. There were missed opportunities to intervene and assess Mr Nottle in the period leading up to his death. It is not possible to determine whether or not this would have changed the outcome. At this time, Mr Nottle was experiencing a range of other social stressors including his isolation arising from the pandemic restrictions, his difficulties with accessing employment, and his return to independent living. He had experienced significant psychological difficulties which had not proved amenable to treatement. Any or all of these factors may have played a part in his decision making. It is also possible that his decision

	making became affected by delusional thoughts and beliefs. Mr Nottle's behaviour in taking a substantial overdose of his prescribed medication was either a cry for help or an attempt to secure the involvement of additional specialist mental health services. He did not intend his own death.
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) Evidence was heard regarding the operation of a triage for patients who may be experiencing a mental health crisis. A practice had developed of bypassing specialist mental health assessment by means of telephone workers making their own judgments about the level of risk a person presents to themselves and others, and a judgment about whether or not they require urgent mental health assessment and / or treatment, based on a very limited criteria. This had the result of only a very small proportion of potentially unwell patients being considered by a person with qualifications to assess and treat mental health. This was a culture and practice which stood in conflict with the procedure the Trust had in writing for the role of the telephone workers. I was also concerned regarding the apparent lack of involvement of a care co-ordinator at the Trust, given that a variety of agencies and persons were involved in seeking to assist and treat Mr Nottle. Lastly, I was concerned that there was evidence of a lack of clarity of thinking within the multi-disciplinary team in relation to the decision to discharge Mr Nottle and the apparent recalcitrance of the multi-disciplinary team in relation to repeated re-referrals into the service. This may be linked with the lack of care co-ordination or may be a cultural or practice issue within the operation of the multi-disciplinary team. It is requested that consideration be given to:- 1. Clarifying the role of telephone workers and the steps necessary to ensure that the government guidance regarding access to mental health services is followed so far as is possible within the available resources; 2. Steps to ensure that, for individuals with complex mental health needs involving a range of providers, there is co-ordination of care to ensure that appropriate care is in place and, where necessary, a consistent approach is taken to patients by different organisations or teams working with the patient; and 3. Review of the multi-disciplinary team's decision-making process in light of the issues identified by Mr Nottle's circumstances.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 August 09, 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 **The family of Keith Nottle** **Nottingham University Hospitals NHS Trust** █████ **of Cripps (University) Health Centre** I have also sent it to **The Care Quality Commission** **The Department for Health** **Nottingham and Nottinghamshire Clinical Commissioning Group** 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: 14/06/2022** **Gordon CLOW** **Assistant Coroner for** **Nottingham City and Nottinghamshire**