REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted]**(Chief Officer)** **Ipswich & East Suffolk Clinical Commissioning Group** **The Right Honourable Sajid Javid MP** **Secretary of State for Health and Social Care**
1	**CORONER** I am Peter Taheri, Assistant Coroner, for the coroner area of Suffolk.
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 11th August 2021 an investigation was commenced into the death of Paul Alexander Meadows. The investigation concluded at the end of the inquest on 10th June 2022. The narrative conclusion of the inquest was that: **Paul Alexander Meadows died on 4th August 2021 at 73 Richmond Road, Ipswich, Suffolk. He took a Codeine overdose that caused his death amid a background of both a number of physical health difficulties that he did not feel were remedied by medication and an escalation in mental ill health, to the extent that he was experiencing a mental health crisis. There is not sufficient evidence to conclude that he took this overdose of prescription medication on this occasion intending to take his own life.** **Paul had sought assistance from agencies including the First Response Service, speaking with the latter on numerous occasions. On at least the last occasion he spoke with the First Response Service, the 3rd August 2021, although he did not communicate an immediate intent to end his life, the mental health crisis that he was experiencing was not recognised and there was no onward referral.** The medical cause of death was confirmed as: **1(a) Overdose of Codeine**
4	**CIRCUMSTANCES OF THE DEATH** Paul Alexander Meadows unfortunately suffered with numerous medical problems and, in the last months of his life, his mental health deteriorated. On 4th August 2021, after becoming concerned about him due to telephone conversations with him the night before, family members visited his home address to bring round some of his favourite food, to check up on him, and to see if they could help. They found the back gate, unusually, open, the kitchen door wide open, and Paul sadly had already passed away.

	There were no suspicious circumstances, no evidence of anyone else inside the premises, and multiple empty packets of prescription medication were found. Paul's death was caused by him having taken an overdose of Codeine. The inquest heard evidence that, between July 2020 and February 2021, Paul had made 15 calls to the First Response Service. While there were no calls between February and July 2021, he made further calls to the First Response Service on 15th July, 16th July, 23rd July, and 3rd August 2021. In these calls, he described both physical health and mental health difficulties. In the later calls, while he did not state any immediate intent to take his own life, and denied any plan or intent to do so, he did make remarks to the effect of being fed up with the pain and not wanting to be here any more. In the 3rd August call, he did describe himself as 'suicidal', wanting to die, not coping with life, thinking his head had gone too far, and as thinking he had given up. He described himself as scared that that he might try and take his own life. He also indicated that he had been thinking about self-harming by taking handfuls of pills. While it is fair to note that those are remarks selected from a 40 minute telephone conversation, nevertheless things were said that could have raised a red flag as to suicidality and being in crisis, and which potentially could have prompted consideration of a more urgent intervention. At inquest, the First Response Service acknowledged certain key points: - Even on the 16th July 2021 call, Paul was requesting more immediate help. His saying that no-one was taking him seriously and requesting more immediate help should have raised the level of concern and perceived risk. - The safety plan relied heavily on Paul's motivation, which was precisely what Paul was saying was absent – and that this absence was something that was worrying him. This issue with the safety plan itself raised the level of risk. - There was a clear escalation in terms of a deterioration in Paul's mental health. He appeared to be in crisis but this appeared to go unrecognised. The advice given and lack of onward referral appeared to be an inadequate response. I found as a fact that, on the balance of probabilities, Paul was in mental health crisis on at least 3rd August 2021 and that this was not recognised by the First Response Service practitioner. I found that the omissions to recognise that Paul was in mental health crisis on 3rd August 2021 and to make a referral onward for crisis or other urgent or emergency intervention did more than minimally, trivially or negligibly contribute to Paul taking the overdose the following day, even though I could not safely conclude what Paul's intentions were in taking that overdose.
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 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. – The Norfolk & Suffolk NHS Foundation Trust accepted that there were broad issues in relation to thoroughness of risk assessment and safety planning in other cases as well as Paul's case. There were inconsistencies in judgement of triage scale and the level of professional curiosity around risk and suicidal ideation. It was accepted that, in Summer 2021, due to resource pressure – specifically, a discrepancy between the anticipated activity and the actual, significant, volume of callers, there were occasions when First Response Service practitioners did not have enough time to gather the required information and properly to triage and risk assess.

	The evidence was that, although the position now varies considerably from day to day, due in particular to difficulties with vacancies it would be unfair to say that staff do not still feel pressured at times on calls. The evidence was that the difficulties in recruitment are associated with differences in funding for the First Response Service between the commissioners for different counties. For example, there is a significant difference between the funding available to Norfolk and to Suffolk, despite both counties having a similar volume of calls. The Commissioners are aware of the number of calls unanswered because of practitioners being unable to take the calls received and the matter remains one that is raised with the Commissioners on an ongoing basis and subject to ongoing negotiation. Nevertheless, the Court has, to recap, received evidence that, given difficulties in recruitment arising out of the level of funding received by the First Response Service in Suffolk, it remains the position that practitioners do not always have sufficient time on calls to gather the required information and properly to triage and risk assess. Where, for these reasons, First Response Service practitioners are not able properly to triage and risk assess, this creates a risk of future deaths that will occur or will continue to exist in the future. The evidence was also that this is not just a concern in one county, but one that is experienced nationally.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe each of you and / or 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 24th 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: - Paul's family - Norfolk & Suffolk NHS Foundation Trust I am 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**29th June 2022** **Peter Taheri**