REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Rt Hon Steve Barclay MP: Secretary of State for Health and Social Care** **2. [redacted]: Chief Executive, NHS England**
1	**CORONER** I am Edmund Gritt, Assistant Coroner for the coronial area of South London.
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 6th July 2021 an investigation was commenced into the death of Patrick Soames, who was 24 years old when he died on 21st June 2021. I assumed conduct of that investigation on about 18th February 2022 and I concluded that investigation at the end of Patrick's inquest on 21st February 2023. The conclusion of the inquest was one of suicide with a medical cause of death: Ia suspension.

4	**CIRCUMSTANCES OF THE DEATH** Patrick lived at home with his parents and was employed. However, in the final month of his life, Patrick experienced a severe emotional deterioration. He engaged in repeated episodes of serious self-harm including cutting his arms, medication overdose and uncharacteristic excessive alcohol misuse. At one point, he briefly went missing when he travelled to Yorkshire – where he also self-harmed. On 9 occasions during that final month, Patrick attended various hospital accident and emergency departments (in different NHS Trust areas), following incidents of self-harm. Some incidents also involved police contact. Patrick, however, declined to engage with psychiatric liaison services on these occasions and abruptly terminated a brief engagement with psychiatric assessment services following referral. Patrick had mental capacity to refuse treatment.
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. – 1. 5 NHS Trusts and 3 police forces in different geographic areas had contact with Patrick in the final month of his life and each thereby gained some information about the risk to him. However, that information was by reason of the agencies falling into different geographic areas. There was no single effective global focus for the information being acquired piecemeal about Patrick's pattern of serious self-harming behaviour. The various agencies were significantly impeded in forming a single clear picture of Patrick's pattern of behaviour (which was particularly necessary in circumstances where he was not engaging and therefore not assisting in providing a complete history himself). 2. GPs act as a repository for information about contact with other clinical agencies (such as attendances at accident and emergency departments) and therefore serve as a point of contact for information about past history. However, I heard evidence at inquest from accident and emergency consultants that it is either not possible to access information held by a GP practice out of GP surgery hours or where it is possible to do so that is only available if the GP is in the same geographic area as the accident and emergency department. Several of

	Patrick's attendances at accident and emergency departments were out of GP surgery hours. 3. I was informed at inquest that one local authority (in whose area Patrick resided) had been made aware by police of the risk to Patrick following one of his self-harm incidents (in respect of a particularly important piece of information) and had relayed that information to a 6th NHS Trust (not one of the 5 from which I heard evidence at inquest) but Patrick did not reside in that Trust area. Those Trusts which did have direct contact with Patrick were never made aware of that piece of information nor had any means of accessing it. 4. I heard evidence that there is no national 'risk flagging' system: for example, when a person attends an accident and emergency department having self-harmed, the fact of a previous self-harm attendance at a different accident and emergency department is not systematically flagged up. 5. In summary, there was no single effective global focus consolidating the information which was flowing into the various agencies about Patrick; no global focus to which those agencies could in turn refer in emergency to obtain the totality of information about Patrick's recent pattern of behaviour; no national 'risk flagging' system to alert those agencies to his significant recent history.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 13th June 2023. 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] (Patrick's parents) (2) Croydon Health Service NHS Trust (3) Surrey and Sussex Healthcare NHS Trust (4) South London and Maudsley NHS Foundation Trust (5) Surrey and Borders Partnership NHS Foundation Trust (6) London Borough of Sutton I have also sent it to the MPS, Keston Medical Practice and Rotherham NHS Foundation Trust who may find it useful or of interest. 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	**18th April 2023**  **Assistant Coroner (South London)**