REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust** **2. Lead Commissioner for mental health services, Nottinghamshire Integrated Care Board**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of 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 the 1st March 2022, I commenced an investigation into the death of Thomas Jayamaha. The investigation concluded at the end of the inquest on the 15th March 2023 The conclusion of the inquest was Suicide
4	**CIRCUMSTANCES OF THE DEATH** Tom took his own life on by taking Pentobarbitol, that he had ordered from a website abroad. He had Autism Spectrum Disorder (ASD), and a long history of suicidal ideation, with previous self harm/suicide attempts. He was aged twenty three when he died. Tom had long term mental health difficulties, and he was repeatedly referred to the Nottinghamshire Healthcare NHS Foundation Trust by his GP, with the GP asking for ongoing psychological support, as Tom was considered too great a risk for him to be seen by Primary Mental Health services. He had a number of factors in his life that made him vulnerable to low mood and suicidal ideation, including his ASD diagnosis, a history of sexual abuse, difficulties in his family relationships, and that he was in a long term coercive and controlling relationship, that was not understood by Trust staff. Tom was also unaware of the local mental health team treatment plan for him when he died, and reportedly felt that the Trust could not help him as referrals were repeatedly rejected by teams across the Trust.
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. Delayed progress of the Autism Strategy work across the Trust. I ask that the Nottingham and Nottinghamshire Integrated Care Board provide a

	joint response with the Trust to address this concern, as I accept progress with the Autism work will depend upon resources and the agreed Commissioning of specific services 2. Insufficient progress with Complex case management 3. The Serious Incident Investigation process I am not reassured that necessary actions to address these serious issues identified are in place.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe you 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 the **2nd 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. For the avoidance of doubt, I will require a response from the Chief Executive of the Nottinghamshire Healthcare NHS Foundation Trust, to all three matters of concern, with collaboration with the Nottinghamshire Integrated Care Board to ensure a full response to the first matter. .
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: 1. [redacted], Parents of Tom 2. [redacted] 3. The GP, [redacted] 4. Nottingham City Council (for the attention of the Adult Safeguarding service) 5. [redacted] The Human Flourishing Project 6. [redacted] The Tomorrow Project 7. [redacted], Nottinghamshire Sexual Violence Service 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	**4th April 2023** **Dr E A Didcock**