REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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	THIS REPORT IS BEING SENT TO: **1. <u>The Ministry of Defence</u> [care of [redacted] GLD Defence Private Law and Inquests Team] for the attention of:** a. The Rt Hon Dr Andrew Murrison MP**, Parliamentary Under Secretary of State (Minister for Defence People, Veterans and Service Families)** b. The Rt Hon Johnny Mercer MP. **The Minister for Veterans' Affairs** c. The Rt Hon James Heappey MP**, Minister for Armed Forces** d. The Rt Hon Ben Wallace MP, **Secretary of State for Defence** **2. <u>Nottinghamshire Healthcare NHS Foundation Trust</u>** [for the attention of [redacted], Chief Executive; [redacted]- Executive Director of Mental Health; [redacted] Newham- Deputy Chief Executive; [redacted]- Executive Director of Community Mental Health Services; [redacted]- Executive Director of People and Culture] [**care of [redacted]**]
1	**CORONER** I am Sophie Cartwright KC, Assistant Coroner for the Coroner area of Derby and Derbyshire Area
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 In 2018 an investigation was commenced into the death of Jonathan "Jonny" Philip Cole [JC], aged 39. The investigation concluded at the end of the Inquest on 25 April 2023. The conclusion of the Inquest was a Narrative Conclusion namely: Narrative Conclusion a. JC developed Post Traumatic Stress Disorder as a result of

at least three traumatic experiences whilst serving in the British Army in Afghanistan on operational tour in 2009 one of which represented a direct threat to his life (where he also suffered physical injuries including hearing loss and tinnitus, shrapnel injuries following a Rocket-Propelled Grenade attack (RPG);

[**Note: This service had been with 2 Rifles as part of Operation Herrick 10.]**

b. JC had made multiple attempts at suicide and self-harm beginning in January 2010 which were caused or materially contributed to by his unresolved symptoms of PTSD, culminating in a final and successful suicide attempt in August 2018;

c. JC did not receive Eye Movement Desensitisation and Reprocessing [EMDR] for those symptoms of Post Traumatic Stress before the summer of 2012, it consisted of no more than 8 sessions of EMDR, which on balance of probability proved latterly to be insufficient albeit the EMDR did provide JC with temporary improvement and some alleviation of symptoms of PTSD in 2012/2013;

d. JC's intrusive memories of the RPG incident were not verified as having been fully processed in the presence of JC's treating CPN before EMDR was discontinued in 2012 albeit JC had confirmed his belief in 2012 that he had managed to self-process that memory;

e. JC received no psychological trauma therapy from 2013 onward up until the time of his death other than the EMDR provided whilst still in the British Army;

f. JC left the Army in 2013 without a formal diagnosis of having had PTSD as a result of operational trauma. This was a failure and a diagnosis of PTSD was appropriate at that time;

g. JC''s unresolved symptoms of PTSD caused or contributed to episodic periods of profound mental health crisis, often preceded, and accompanied by, thoughts and attempts to end his life by way of overdose, and latterly hanging. His unresolved symptoms of PTSD also contributed to use of

alcohol and drugs to manage the symptoms which in turn led to marital and relationship problems and financial problems;

h. JC's PTSD was accompanied by alcohol and drug use, exacerbating the severity of the underlying condition;

i. The continued lack of any official recognition, acknowledgment, or diagnosis on the part of the MOD of his PTSD in the context of JC's attempts to access financial compensation for his condition, was a failure and materially contributed to a deterioration in his mental health state in the period following his discharge from the Army up until his death and resulted in JC making contact again on 8th June 2018 which was not responded to before his death;

j. The Risk assessment and Care Plan completed on 28th January 2018 was inadequate and under estimated the risk of suicide for JC;

k. There was a failure to conduct a psychiatric review in January 2018 despite a referral for psychiatric review this failure also caused unnecessary delay before a medication review took place;

l. The Risk assessment and Care Plan completed on 14th May 2018 was inadequate and underestimated the risk of suicide;

m. JC's mental health had deteriorated significantly in 2018 and deterioration continued whilst under care of local mental health team and with knowledge that no psychological trauma therapy was being provided;

n. By the beginning of 2018 JC's medication was no longer proving effective as he became increasingly depressed, as well as socially, and occupationally isolated. This led to a change in medication in June 2018, which whilst appropriately indicated was not effectively managed and documented as ineffective on 28th July 2018 when consideration should have been given to appropriately increasing the dose of Paroxetine to assist JC's low mood;

o. Further risk assessments and Care plans should have been completed when Fluoxetine was reduced and removed and Paroxetine introduced;

p. A further risk assessment and care plan should have been completed on 26th July 2018 in light of having elicited JC's recent arrest and changes in his psycho social position

	including issues of accommodation and financial pressures. This consultation underestimated the risk of suicide. There was a failure of the treating mental health professional to identify that JC was to appear in court 8.8.18. There was a lost opportunity therefore to make contact with the police/ CPS and to liaise with the criminal justice liaison and divergence with relevant information as to the medication review underway and relevant factors of JC's mental health. There was an under estimation of the risk of suicide on 26.7.18 by not identifying the upcoming court date of 8.8.18 and offering support to JC; q. There was a missed opportunity throughout 2018 to refer JC to the Transition Intervention and Liaison Service [TILS] and the Centre for Trauma Resilience and Growth.
4	**CIRCUMSTANCES OF THE DEATH** On the 9th August 2018 at a location of Old Stone Bridge, Butterley Park, Codnor Park, Ironville, Derbyshire Jonny Cole was found hanging [redacted] having acted with the intention to end his life. Jonny had PTSD, anxiety, suicidal ideation and was under the care of his local mental health trust. Jonny had not been seen since leaving his home on the afternoon of 7th August 2018 and was due in court on 8th August 2018 to face charges of criminal damage but did not attend.
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: **Ministry of Defence** **1. I have a concern as to the number and availability of psychiatrists and psychologists within the Ministry of Defence and accessible to serving personnel. This concern extends to ensuring a soldier receives access to appropriate treatment including diagnosis.** **Diagnosis is also important as under the Armed Forces**

Compensation Scheme, mental disorders must be diagnosed by a relevant accredited medical specialist, namely, a medical practitioner whose name is included in the specialist register kept and published by the General Medical Council as required by section 34D of the Medical Act 1983.

At the time Jonny Cole was accessing the DCMH Lisburn, [redacted] gave evidence that there was just one psychiatrist for the whole of Northern Ireland who also had duties in the DCMH Kinloss, Scotland and no psychologist. 2 Rifles was based in Northern Ireland and at this time issues relative to Operation Herrick 10 and traumatic combat experience were being identified.

[redacted] told me relative to the impact of Operation Herrick 10, "*Well all I can say is that we knew that we had a problem with post traumatic stress disorder and there were several suicides in Northern Ireland before I arrived. I can't comment on that too far because there was a board of inquiry and the regiment was moved from the isolated position of Ballykinler to Lisburn because of that. In order to make them less vulnerable,"*

Following the evidence given by [redacted], I queried the Service expectations for the number of psychiatrists covering Northern Ireland and Scotland in 2010-2013 and now, and was provided with the following response from Defence Medical Services.

"NI is now covered by DCMH [redacted]. The staffing of mental health posts is however now lower that that at the time the Coroner is concerned with. This is partly due to reducing military population in NI which would not justify a full-time consultant and partly due to significant difficulties in staffing mental health posts. ***Recruiting more mental health clinical staff is something that the DMS is working hard to do; however, the pool of mental health workers for both the DMS and NHS to draw from is finite.***

Additionally, the DPHC Standard Operating Procedure on management of referrals makes some reference to this. Though it does not specify a manning ratio, it does give guidance on waiting list management (para 13). In essence it states an Officer Rank 7 or Civil Service Band 6 has day to day responsibility for monitoring waiting lists and has direct access to the clinical lead, they are also responsible for all review arrangements and Multi-Disciplinary Team actions which are in place. It would follow from this if waiting lists are becoming unmanageable the named individual would be able to escalate the problem".

Chief of Staff at Defence Medical Services Headquarters, [redacted]

[redacted] gave evidence when asked about the current position as to whether there was shortage of consultant psychiatrists and psychologists within the DCMHs, that, "*we certainly have a shortage of mental health clinical staff at the moment. There are a lot of initiatives in place to try and continue to recruit those both military and civilian and we are working very hard at producing a more resilient and enduring so that we can actually build a career structure for our mental health practices going forward,* ***something we have lacked in defence up until now."***

This concern also extends to the knock-on effect that this apparent shortage of psychiatrists and psychologists has upon later claims for compensation by veterans as mental disorders must be diagnosed by a relevant accredited medical specialist, namely, a medical practitioner whose name is included in the specialist register kept and published by the General Medical Council as required by section 34D of the Medical Act 1983.

2. **I have a concern that the Vulnerability Risk Management Process [Suicide Vulnerability Risk Management as was] is Unit led and that DCMH clinicians do not have a greater role in influencing the Army's vulnerability risk management (VRM) process for suicidal soldiers.**

3. **I have a concern about:**
   a. the training and experience of the Medical Advisors at Veterans UK providing advice under the Armed Forces Compensation Scheme.

   b. rejection of claims for PTSD under the Armed Forces Compensation Scheme if there is not a formal diagnosis by a consultant psychiatrist or psychologist but evidence of PTSD within medical records from other medical professionals.

[redacted] was a retired GP who went on to work as a part-time medical advisor at Veterans UK in October 2013 and rejected Jonny's claim for compensation for PTSD and psychological injury under the armed forces compensation scheme. [redacted] had no specialist knowledge of psychiatric or mental health issues and had had no specialist training in that area.

In evidence [redacted] accepted that there was an issue with the advice he gave that resulted in Jonny's claim for compensation being rejected. In evidence [redacted] told me:
"*Q. Can I ask you: The approach that you adopted on Jonny Cole's case, in respect of his claim to PTSD, would you have applied a similar approach to other files or claims of veterans in respect of PTSD?*

	A. It's possible, I suppose, but I suppose as you gain experience and understanding of how the scheme is to be applied, then it changes. When I looked at this a week ago, which is when I first saw the documents, I could see straightaway the issue, but obviously I didn't see that in December 2013. *Q. So, then, can I ask you: Obviously, when you reviewed the file as part of your preparation to give evidence, and to be fair to you, you had not had that opportunity when you provided your statement, you say you saw straightaway what the issue was. Can you tell us what it was that you saw when you reviewed the file, and what that issue is?* *A. That there was a consultant diagnosis[1].* *Q. Would there ever have been a scenario where you had rejected a claim, as part of the advice that you had given to the case workers, where a veteran would come back and say… Be raising issues again about PTSD, would it come back to you to review or would it go to a different medical adviser?* *A. It could be either, and in fact if a review was requested or an appeal requested, I think it had to be a different case worker, but I don't think it necessarily had to be a different medical adviser.* *Q. Just so then I am clear about you reviewed the file with obviously then the knowledge… Admittedly you do not work for Veterans UK anymore, but you had had the number of years then working and giving advice. But when you saw straightaway what the issue was, and there was a consultant diagnosis, if you had reviewed Jonny Cole's case nearer to the end of your time at Veterans UK, what would your advice have been in respect of Jonny Cole's claim, to the case workers?* *A. Well, it would have been a different approach, because I would… Once you have accepted that there is a diagnosis, then the next stage is what's the cause of that, and is that predominantly caused by factors of service? And then, if the answer to that is yes, on the balance of probabilities it is caused by factors of service, then I would have recommended an award.* *Q. Then, in terms of what you have effectively told us, that if you had reviewed this case later down your experience with Veterans UK, Jonny certainly would have got over the hurdle of a consultant diagnosis—* *A. Yes.* *Q. —but again, having reviewed the documentation, and obviously you were the individual that was asked to provide advice as to*

[1] Adjustment Disorder. [redacted] also gave evidence that he would have applied the diagmosis of PTSD in remission.

causation, to provide advice as to whether or not on the balance of probability it is linked to factors relating to service… Have you gone on to consider that aspect also?

A. Not particularly no, but I would have thought there's enough there to say yes it was."

[redacted] indicated that the "narrow look" he undertook in respect of Jonny's claim for compensation was due to, *"Certainly not lack of time. I think it would be fair to say possibly lack of experience, and lack of training. And I think the emphasis I think was quite strong on that principle, even within the table tariff for the AFCS, on the section 3 I think it is, which is for psychological things, I think it does state it there, that a diagnosis can only be accepted by accredited consultant psychiatrist, so I suppose that in a sense emphasises it, and perhaps that's why it was so prominent in my thinking*."

[redacted] gave expert evidence to me about the impact of the denial of compensation by Veterans UK for psychological injury and decisions where there is a denial of payments to which a veteran is entitled which, invalidates psychological injury, can cause hostility and being aggrieved and lead to self-destructive behaviour by the veteran.

Jonny Cole himself raised by email to Veterans UK in June 2018, and shortly before his death in August 2018, the ongoing issues he was having with his PTSD that was getting worse and the impact it was having on his mental health, which had led to hospital admission due to overdose, and included a letter that identified that Jonny had reported thinking of suicide on a daily basis.

Jonny Cole did not receive a response to this email before his death but when this response was provided by letter dates 20th August 2018 it stated;

"*We cannot take any further action on your claim at the moment. This is because the scheme rules state when considering a claim for a mental disorder, we require a diagnosis made by a clinical psychologist or psychiatrist at consultant grade. We are unable to accept a diagnosis made by a GP or community psychiatric nurse.*

Evidence we have considered so far: We have looked at the evidence we already have but it does not include confirmation of a formal diagnosis.

What happens next: In order for us to be able to fully consider your claim, please could you provide us with evidence of a diagnosis from a consultant psychologist or psychiatrist. We are unable to take any further action until we hear from you. If we do not receive a response from you within 3 months of our request, your claim will be closed."

[redacted] suggested that thought needed to be given to having a Panel that is more representative of all stake holders not just the MOD and for more credibility to be given to civilian diagnosis and evidence and for there to be someone independent to review the cases.

Nottinghamshire Healthcare NHS Foundation Trust [The Trust]

4. **I have a concern that the Trust is doing too little to identify and address the risk of suicide for Veterans.**

A 2021 Nottinghamshire Suicide Prevention Action Plan to which the Trust was a partner identified for Veterans the need to, "*undertake evidence review on the needs of veterans in relation to mental health and suicide, to inform future developments. Promote and raise awareness of the Op Courage MH Pathway and Armed Forces Health eLearning (commissioned by NHSE/Improvement Armed Forces Health). Ensure an ongoing dialogue with NHSE/Improvement around provision of mental health, suicide prevention and postvention. bereavement support to veterans and engage in any NHSE Midlands masterclass with Integrated Care Boards (ICBs) - date to be agreed. Identify veterans within the local Suicide Cluster Response Plan Guidance in the first annual refresh Review learning from the NHSE/Improvement review/investigation of Serious Incidents."*

Despite this, the Trust's Suicide Prevention Strategy and Suicide Prevention Annual Plan 2020-2023 provided to me and due to be reviewed this year **does not specifically touch upon Veterans.** I am told that there is a commitment to ensure this is a key feature of the review already commencing within the organisation.

5. **I have a concern that there is:**
   a) **a lack of understanding as to the appropriate services to make referrals to for Veterans by Trust mental health practitioners;**
   b) **a lack of understanding as to services available for Veterans;**
   c) **too much emphasis on Veterans being solely responsible for self-referral, with no assistance to assist in accessing appropriate services;**
   d) **A lack of understanding (or effort) as to how to request and obtain military DCMH medical records.**

I acknowledge that steps have been made recently by the Trust to, *"liaise directly with Operation Courage in order to request their attendance at staff team events to further improve liaison and staff understanding of their pathways and exactly what their offer to Veterans*", however it is essential that these pathways are known by all mental health practitioners and engagement undertaken with the services to which a Veteran is referred, to check if this is an appropriate referral.

This needs to include an understanding by mental health practitioners of what is in fact offered by: Operation Courage; the Centre for Trauma Resilience and Growth; Help 4 Heroes; Combat Stress and other charities and in particular what can be offered by way of psychological and trauma therapy.

I was not reassured from the Trust witnesses who gave evidence to me who had involvement with Jonny that they had this understanding or of the specific needs of Veterans.

As [redacted] told me, it takes a lot for a veteran to put their hand up and ask for help and tend not to ask for help until things are really bad and there is a need to act quickly and as compassionately as possible to work with that window of opportunity and to assist the Veteran in making the referral.

6. I have a concern as to the quality of the Trust's Investigation Report and that the process of review is not sufficiently robust

I acknowledge that the Trust recognises that the investigation reports provided in respect of Jonny Cole's death were unsatisfactory and also and that the review of Rapid Response Liaison Psychiatry involvement in 2022, "*was a missed opportunity to retrospectively review the investigation in its entirety*". However, it is of concern that the 2022 review was also insufficient and inadequate.

The concerning information relating to the attempt Jonny made to ligate in a tree was not analysed. [redacted] told me that an attempt on life by suicide increases the risk 100-fold that you would die by suicide in the next 12 months and is the most significant risk factor in Jonny's history that massively elevated the risk until that period of time has lapsed which requires clinical risk assessment].

	The Investigation report and the updated report following review failed to identify themes of concern[2], and did not reassure me that the Trust had taken an appropriate response to investigate the concerning facts of this case and to ensure lessons were learned and not repeated for other patients and appropriate audit undertaken. I am told that the Trust is, "*committed to continuing our improvement journey in this area",* however, I remain concerned that the Trust's investigation was insufficient, lacked robustness and did not fully engage with the duty of candour.
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 31st July 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: [redacted]- Jonny's wife. [redacted] – Jonny's partner. [redacted] -Jonny's father. Ministry of Defence Nottinghamshire Health Care Foundation Trust

[2] By way of example the issue as to the failure of a medication review by a psychiatrist in January 2018 despite a request for the same with no proper analysis as to how Jonny's name was removed from the board; no robust analysis as to the change of Jonny's medication and why medication had not been increased or addressed by an updated risk assessment and care plan; no analysis of the missed opportunity relating to risk assessment around Jonny's arrest and lack of liaison with criminal justice partners to inform risk assessment.

	Derbyshire Constabulary Derbyshire Healthcare NHS Foundation Trust I have also sent it to: Op Courage Midlands Lincolnshire Partnership NHS Foundation Trust – [redacted] 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	 **Sophie Cartwright** **Assistant Coroner** **Derby and Derbyshire Area** **5th June 2023**