REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. The Right Honourable Steve Barclay MP, Secretary of State for Health and Social Care 2. [redacted], Chief Executive NHS England
1	**CORONER** I am James Dillon, assistant coroner, for the coroner area of Mid Kent and Medway
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 18th October 2022 I commenced an investigation into the death of Roger Adrian Stevenson, age 28. The investigation concluded at the end of the inquest on 29th September 2023. The conclusion of the inquest was a narrative stating: "Roger Adrian Stevenson was found deceased in room [redacted] which is accommodation in which he had been staying. He was found deceased on the 2nd of May 2022 having last been seen alive on CCTV on the 30th of April 2022. Post-mortem evidence indicates that he had a morphine blood level [redacted] which in a range that could have been fatal to him. He had a lengthy history of mental health issues and had been lost to the mental health services in the months leading to his death." The medical cause of death was recorded as: 1(a) Fatal toxic morphine intoxication
4	**CIRCUMSTANCES OF THE DEATH** Roger Stevenson was found deceased in his room at [redacted] (being state funded supported accommodation) during the early hours of the 2nd of May 2022, he was last known to be alive (from CCTV footage) on the afternoon of Friday 30th April 2022. The post mortem evidence including toxicology has established that the medical cause of death was fatal toxic morphine intoxication. While Roger's death was initially not treated as suspicious a later disclosure by another resident led to police investigation [redacted]. It was believed that Roger had been abstinent of drugs for some time prior to this.

	No evidence, beyond the account of the other resident (who failed to attend court to give evidence), was identified from which any intention by Roger to self-harm could be inferred. The evidence indicated that Roger had become lost to mental health services through the local NHS Trust, namely Kent and Medway NHS and Social care Partnership Trust (”KMPT”). Roger had last been formally assessed under the Mental Health Act in July 2021 although on that occasion he was not assessed to be detainable. No 72 hour follow up, after Roger was discharged, was carried out. No consideration appears to have been had to the provision of depot type injections to help Roger to comply with his Quetiapine regime. Roger had engaged with other community services including Kent Enablement Recovery Service. However family concerns were highlighted that Roger would go through a cyclical pattern of illness in which he would have placid periods and in which he would be told to engage with community services but there were not arrangements in place to ensure that he did so. It was then felt that only when Roger had manic periods of crisis would mental health services become significantly engaged with him. The family highlighted concerns about a lack of communication and multidisciplinary approach between agencies (including Kent County Council and KMPT) to assist Roger into maintaining a stable lifestyle rather than a position where the cyclical pattern of mental health issues would continue (depot injections being one example). It was identified that Roger had been transferred between Community Mental Health Team in Medway and Maidstone, delays in these transfers occurred and it was shown that transfer policies were not followed so far as written and ,as bets practice face to face, handovers were concerned. It was also identified that Roger was among 149 individuals awaiting allocation of a care co-ordinator owing to KMPT resourcing issues.
5	**<u>CORONER’S CONCERNS</u>** 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** identified within evidence are as follows were as follows: 1. That Roger, as a vulnerable adult who had been recognised to be in need of care and support, had been lost in the system (e.g. with a lack of 72 hour follow up in 2021) and may have been inappropriately housed. 2. There was a need for recognition of service users with cyclical chronic mental ill health issues – in this case being that help Roger received tended to be only at the time of crisis thus doing nothing to address long-term underlying chronic conditions. 3. That there was a lack steps taken to address isolation felt by service users suffering ill health where there were likely to be substantial delays in accessing services (such as being allocated a care co-ordinator) and receiving treatment which could lead to further feelings of desperation leading to thoughts of suicide and self-harm. 4. KMPT needed to ensure service users do receive a 72 hour follow up after presenting to an Emergency Department, 5. KMPT needed to consider provision of long-acting injection type (depot) medication to ensure compliance, particularly where a service user may have to wait substantial periods of time for other services such as therapy.

	6. That mental health practitioners did not have means by which to engage with the families of service users, effectively recognising such families as an additional resource able to support mental health treatment by monitoring service users and encouraging them to engage with such treatment (and as an adjunct to that a way of noting that where consent has been given by a service user to disclose matters to family members this is clearly noted so that mental health staff are aware of it and can act promptly in so doing). 7. That staffing shortages continue to be a major issue in mental health treatment and that although efforts towards recruitment may alleviate this to some extent KMPT adding text to template letters giving a little more information to service users as to when they may expect to be seen is unlikely to be sufficient. Where such text is used though there would be an opportunity of referring to 3rd party agencies from whom additional support can be sought including charities like the Samaritans or emergency numbers (999 and 111).
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 8th January 2024. 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 namely the family and Kent and Medway NHS and Social care Partnership NHS Trust. 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	**Dated - 13th November 2023**  **Assistant Coroner Mid Kent and Medway**