*NOTE: This form is to be used **after** an inquest.*

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. Rt Hon V Atkins, MP, Secretary of State for Health and Social Care** |
| 1 | **CORONER**<br><br>I am Andrew Cox, the Senior Coroner for the coroner area of Cornwall and the Isles of Scilly. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br>On 3/6/23, I concluded the inquest into the death of Nicolas Gerasimidis. He was found hanged at his home address on 3/6/23.<br><br>I recorded a conclusion of Suicide at inquest. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mr Gerasimidis had a history of mental illness manifesting as OCD and anxiety. In 2022, his condition deteriorated. His GP referred him twice to the Community Mental Health Team but the referrals were rejected with medication being prescribed instead, together with advice to contact Talking Therapies.<br><br>He was taken on to CMHT workload after being assessed by the Psychiatric Liaison Team in Royal Cornwall Hospital in November 2022. The preferred course of treatment was psychological treatment in the form of Cognitive Behavioural Therapy with Exposure Response Prevention. There was a waiting list of a year.<br><br>In May 2023, Mr Gerasimidis became worse. It was felt an informal admission to hospital was required but a bed was not available. He was found hanged at his home address on 3/6/23. |
| 5 | **CORONER'S CONCERNS**<br><br>During the course of these inquests, the evidence has revealed matters giving rise to concern. In my opinion there is a risk that future deaths will |

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| | occur unless action is taken. In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows.<br><br>The Trust's Patient Safety Review identified the following concerns:<br><br>- When Mr Gerasimidis was referred by his GP to the community mental health team, he was screened out, in part, due to challenging staffing issues;<br>- No care coordinator was appointed owing to a shortage of staff;<br>- The Trust had and continues to have vacancies at consultant level;<br>- The family was wrongly advised the Trust was not commissioned to treat OCD;<br>- The family was not informed of a nearest relative's right under the Mental Health Act to request a case review by an AMHP;<br>- Psychological treatment in the form of Cognitive Behavioural Therapy with Exposure Response Prevention had a waiting list of one year;<br>- In May 2023, when it was felt Mr Gerasimidis required an informal admission into hospital, no beds were available.<br><br>The difficulties with staff recruitment and bed availability are long term problems in the Cornwall coroner area. The Patient Safety Review suggests Cornwall has fewer beds for its population than other areas. It is the persistent or recurring nature of these concerns that leads me to believe action should be taken. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 30/3/24. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested or proper Persons:<br><br>- The family;<br>- [redacted] Chief Executive, Cornwall Partnership Foundation |

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| | Trust;<br>- [redacted], Chief Executive, Integrated Care Board;<br>- [redacted], GP.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **[DATE]**<br><br>**30/1/24** **[SIGNED BY CORONER]**  |