REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Executive of NHS England, Skipton House, London, SE1 6LH**
1	**CORONER** I am Dr Julian Morris, senior coroner, for the coroner area of London Inner South.
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 27 November 2020 I commenced an investigation into the death of Mr Oliver Beswetherick, aged 24 years. The investigation concluded at the end of the inquest on 11 December 2023. The conclusion of the inquest was a narrative conclusion.
4	**CIRCUMSTANCES OF THE DEATH** Mr Beswetherick had suffered from depression and bulimia, since 2015 and 2018 respectively. During 2019 – 2020 he was seen regularly by a therapist and consultant psychiatrist, the latter confirming the diagnosis of bipolar affective disorder type II for which he prescribed medical treatment. Up until 22 August 2020, Mr Beswetherick was well. On 29 August he attended A&E and was seen by the psychiatric liaison nurse, who, after assessing him wrote to his consultant, whom he was due to see a couple of days later. That review took place on 31 August and the consultant immediately referred Mr Beswetherick back to his GP for urgent referral to the CMTH/ crisis teams. Mr Beswetherick and his partner sought updates from the practice over the following days, 1-3 September 2023. On 3 September, following further discussions about Mr Beswetherick's suicidal nature, he was referred by his GP to the CMHT. Their assessment was that he should be seen face to face. However, Mr Beswetherick had moved out of the local catchment area (East London) to south of the river (Southwark). He was therefore advised to attend his local A&E to see the local psychiatric liaison nurse who would be able to

	refer into the local services. No direct referral to the either the psychiatric liaison nurse or local services was made. On the morning of 4 September 2020, Mr Beswetherick was identified, having fallen from his flat to the ground. He was pronounced dead at the scene by LAS, the MPS deeming the scene non-suspicious. A note was found.
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) It became evidence during the inquest that CMHT/ Crisis teams do not have contact details of: (i) Psychiatric liaison nurse services in neighbouring (out of their locality) boroughs based in Accident & Emergency departments, or details of (ii) CMHT/ crisis teams in neighbouring boroughs. Such contact could provide for direct referral, contact and passing on of knowledge of cases between neighbouring organisations, especially when individuals have already been assessed and asked to attend for a face-to-face consultation. Otherwise, those individuals who seek help, may have to revisit the same process of being interviewed on multiple occasions with a sense of déjà vu and anxiety that they are not obtaining the urgent assistance and support that they require. That may lead to them not engaging when they had hitherto made every attempt to do so. To provide those contact details would seem a relatively simple task, so teams could contact each other, and the local psychiatric liaison nurses based within the A&Es.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 Wednesday April 17th. 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:- NOK [redacted] (Mother) [redacted] for Medical Protection [redacted] [redacted] for East London NHS Foundation Trust [redacted] for H Evans [redacted] [redacted] for SLAM 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	**21.02.24** **[SIGNED BY CORONER]** *Dr Julian Morris*