REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive, Central and North West London NHS Foundation Trust- via eamil [redacted], Chief Executive, NHS England- via email
1	**CORONER** I am Professor Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West London
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** Between 5th and 6th March 2024, evidence was heard before the Coroner touching the death of Mr Adrian Michael James. He had died on the 21st June 2021, aged 39 years at St Mary's Hospital, Praed Street, London, following dropping from height. **Medical Cause of Death** 1 a Head Injury b Fall from height **How, when, where and the deceased came by his death:** On 25th June 2021 at approximately 15:30, Adrian dropped from the 4th floor of the block of flats in which he lived. He sustained a serious head injury which rendered him immediately unconscious and caused his death, despite extensive resuscitation at St Mary's Hospital at 16:39 hours. Adrian suffered with Antisocial and Emotionally Unstable Personality Disorders, complicated by depression and substance misuse. He had attempted to take his own life on multiple occasions. He had been more settled in recent years, but his suicidal risk remained high. In the last months of his life, he was under the care of community mental health services, primary care network (PCN) and was being treated with structured psychological support.

	From April 2021, building works at his residence exacerbated his paranoia and from 8th June 2021 this manifested as repeated crisis contact with emergency and psychiatric services- more than 25 occasions up to his death from 8th June 2021. Twice during this time, he was detained on section 136 and then discharged following Mental Health Act Assessment to his usual community care. His care was reviewed daily from 9th June 2021 in PCN meetings, and he was supported by crisis contact, including a home visit when he failed to respond to welfare check calls. On 25th June 2021 he was engaging in a structured psychological support session with a psychiatrist, when police attended to check on him following concerns raised about suicidality from a member of the public. Shortly after police left, he was heard to be screaming and then seen to be hanging off the balcony on the 4th floor of his block of flats. He was seen to let go and fall to his death. At all assessments in the last weeks of his life he had presented with paranoid ideation and with a background risk of suicide, but no increased intent to take his own life. It is likely that his death was due to an impulsive act on his part whilst suffering distress due to paranoia as part of his illness. **Conclusion of the Coroner as to the death:** He took his own life whilst suffering severe and enduring mental illness
4	*Extensive evidence was taken during the inquest from multiple live witnesses, written statements, and exhibited reports. Of relevance to this report in addition to the findings above, which I do not repeat:* Adrian's death as an impulsive act, was not easily predicable and preventable and the emotional variability with which he presented made it difficult for him to be assessed, as he could switch quickly from an agitated state to one in which he was relatively calm. At all times he retained capacity. At no point was he sectionable under the Mental Health Act in the last 2 weeks of his life, although he had been detained by Police twice under section 136. He accepted treatment through community health services and used crisis interventions for support which are likely to have been roughly equivalent to services that he would have received had he been supported by the Home Treatment Team or equivalent during the material time, as this would likely have been by phone call as this was during Covid lockdown. However, despite the sheer number of contacts no pro-active treatment past his usual care and response to crisis calls was offered. Note that in the last 14 days of his life he had received 2 Mental Health Act Assessments after s136 detention, been seen by Liaison Psychiatry at Chelsea and Westminster Hospital and made countless calls for support. Despite him continually denying an active suicidal intent, I remain concerned that whilst albeit there were multiple reviews at MDTs insufficient consideration was given to his risk of impulsive suicide and the possibility of mitigating this risk by a pro-active rather than reactive care package. The evidence of distress caused by paranoia was there. It may be that a more structured support plan would have helped to contain his distress between his fortnightly sessions of structured psychological therapy.

	Despite the obvious deterioration in his paranoia there was no evidence heard that medication was actively considered to help alleviate, this except in hindsight. Home Treatment Team Care (First Response Team) had been considered on 15th June 2021 as part of his assessment by the AMHP, but there is no evidence in his notes from CNWL, that this was considered after this time, despite further crisis contact. Adrian was undoubtedly a complex patient to treat, but when he deteriorated, his treatment sessions were left with the specialist doctor in training and he did not receive assessment by the psychiatric consultant in the community, who in fact never met him, either before he started the structured psychological treatment or when he deteriorated. When the police interrupted his last treatment session, the psychiatrist did not try and call Adrian back to ask how he was and to re- assess his risk, despite the number of crisis contacts, his paranoia with associated distress, his known high background risk of suicide, his risk of impulsivity, emotional instability, and his very recent s136 detentions etc. The doctor discussed what had happened with the team and it was decided to wait and see if police contacted psychiatric services rather than re contact the patient, taking reassurance from police presence, despite police officers wishing to talk to doctor and requesting telephone contact numbers but being unable to secure these before the signal on the call between police and psychiatrist failed. Adrian's phone number was available to the doctor and the PCN team. Police officers are not mental health clinicians. The court found that the lack of re contact with Adrian by the psychiatrist after the treatment session was interrupted, was a failure in care. Police did try and call SPA but hung up after being told that they were 4th in the queue as they expected a wait of hours before being answered at that time. Police did arrange a follow up visit for Adrian by the police night shift. Adrian had declined LAS attendance and refused a lift from the officers to St Thomas's Hospital. However, Adrian had come from the balcony about an hour after the police left. Police systems have now changed, and Adrian would now be checked by health care rather than police. SPA answer times have also improved. It was not until the final witness, who was from the PCN, did the level of consideration and care being given by the PCN become apparent. Both the treating consultant and the PCN Service Lead noted the lack of formal regular input from the treating consultant's team to the PCN MDT. Whilst it could not be said that the matters outlined above contributed to the death on the facts of this case, concerns remain. *This report has also been sent to NHS England, so that the lessons learned from this death may be applied to mental health care services.*
5	**Matters of Concern** 1. That Adrian, despite being a complex patient with multiple psychiatric diagnoses and at high risk of impulsive behaviour and suicide was not seen nor assessed by a consultant either prior to starting psychological therapy or when he deteriorated.

	2. That no pro-active care was considered for Adrian whilst he was in obvious mental health crisis in the last 17 days of his life. 3. That insufficient consideration appeared to have been given to the risk of impulsive suicide with instead assessment focussing on his denial of increased active suicidal intent. 4. That no follow up call or assessment was made to Adrian when his treatment session was interrupted by police attendence, and the treatment call was cut off. 5. That there were inadequate communications between the PCN MDT and those providing the psychological treatment.
6	**ACTION SHOULD BE TAKEN** 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. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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: Sister of Mr James : 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	**7th March 2024.**  **Professor Fiona J Wilcox** **HM Senior Coroner Inner West London** **Westminster Coroner's Court**

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