IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Jonathan Harris
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** [redacted] Chair NHS England PO Box 16738 Redditch B97 9PT
2	**CORONER** Miss Anna Crawford, H.M. Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
4	**INQUEST** An inquest into Mr Harris's death was opened on 21 July 2022. The inquest was resumed and concluded on 4 March 2024. The medical cause of Mr Harris's death was: 1a. Suspension 2. Paranoid Schizophrenia The inquest concluded as follows: Suicide.

	Jonathan Harris was 52 years old and had a diagnosis of Paranoid Schizophrenia. On 24 November 2021 he was discharged following a lengthy psychiatric inpatient stay to Hazel Lodge, which provides supported living accommodation in Camberley and is run by Comfort Care Services Ltd. At the time of his discharge from hospital Mr Harris was prescribed anti-psychotic medication in the form of a weekly depot injection of 600mg Zuclopentixol. Whilst he was living at Hazel Lodge Mr Harris came under the care of his local community mental health team, the Surrey Heath Community Mental Health Recovery Service, which is part of Surrey and Borders Partnership NHS Foundation Trust. In early February 2022, following a request by Mr Harris, the frequency of his anti-psychotic medication was suitably reduced to 600mg fortnightly as opposed to weekly. Thereafter in early May 2022, following another request by Mr Harris, his anti-psychotic medication was further reduced to 600mg every three weeks. The reduction in his medication in May 2022 was premature and was made without exploring signs that Mr Harris appeared suspicious when he was seen by the mental health team on 4 May 2022 and in circumstances in which Mr Harris was known to have a significant life change ahead, namely a house purchase and move, which would entail him moving to a new community mental health team. Thereafter, Mr Harris' mental health continued to deteriorate and on 24 June 2022 it was decided by the Community Mental Health Team that he required an assessment under the Mental Health Act. However, there was no inpatient bed available and therefore the assessment did not take place. Had the assessment taken place Mr Harris would have been detained under the Mental Health Act and admitted to hospital. In the early hours of the morning of 27 June 2022 Mr Harris deliberately suspended himself [redacted], resulting in his death. In doing so he acted with the intention of taking his own life, albeit whilst suffering from a relapse of his paranoid schizophrenia. Mr Harris would not have taken his own life had he remained well and the relapse of his Paranoid Schizophrenia materially contributed to his death. The relapse was precipitated by the initial reduction of his anti-psychotic medication in February 2022 and sped up and exacerbated by the further premature reduction in May 2022. Mr Harris would not have died had an inpatient psychiatric hospital bed been available on either 24, 25 or 26 June 2022.

5	**CIRCUMSTANCES OF THE DEATH** The circumstances of Mr Harris's death are set out in the above narrative conclusion.

6	**CORONER'S CONCERNS** The **MATTER OF CONCERN** is: The court heard that a Consultant Psychiatrist post in the community mental health team that treated Mr Harris has been vacant with no suitable applicants since 1 May 2022. The court heard that this is in the context of a national shortage of suitably qualified psychiatrists. The court also heard that there is an ongoing shortage of available inpatient psychiatric beds in Surrey and that this is in the context of a national shortage of inpatient psychiatric beds. The court is concerned that both of these matters present a risk of future deaths.
7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.

9	**COPIES** I have sent a copy of this report to the following: 1. Chief Coroner 2. Mr Harris's family 3. Mr Harris's executor 4. Surrey and Borders Partnership NHS Foundation Trust 5. Comfort Care Services Ltd 6. Surrey County Council
10	**Signed:** **ANNA CRAWFORD** **Anna Crawford** **H.M Assistant Coroner for Surrey** **Dated this 20th day of March 2024**