REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Rt Hon Victoria Atkins MP** **Secretary of State** **Department of Health and Social Care** **39 Victoria Street** **London** **SW1H 0EU**
1	**CORONER** I am Nigel Parsley, Senior Coroner, for the coroner area of Suffolk.
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 16th June 2023 I commenced an investigation into the death of **Nicola RAYNER** The investigation concluded at the end of the inquest on 23rd February 2024. The conclusion of the inquest was that the death was the result of:- **Suicide, resulting directly from a lack of Mental Health bed provision in Suffolk and nationally.** The medical cause of death was confirmed as: **1a Traumatic asphyxia** **1b Hanging**
4	**CIRCUMSTANCES OF THE DEATH** **Nicola Raynor was verified as deceased at 19:43 on 10th June 2023, at the Addenbrookes Hospital, Cambridge, Cambridgeshire** **On the 6th June 2023 Nicola had been found hanging [redacted] The emergency services attended, and Nicola was taken to Addenbrookes Hospital where she subsequently passed away as the result of a hypoxic brain injury.** **Nicola had a history of poor mental health, and at the time of her death was under the care of the Mental Health Services.** **Prior to Nicola being found hanging on the 6th June 2023, she had earlier that day attended a consultation with a psychiatrist, who had wanted to admit Nicola to a Mental Health ward immediately, however no beds were available.** **Nicola had a few days earlier (on 29th May 2023), also been seen by a Mental Health Nurse at the local Accident and Emergency department, who had also wanted to immediately admit Nicola into hospital, but due to Bank Holiday pressures, again no bed had been available.**

	At the time of her death Nicola had been placed on a waiting list to be admitted to hospital, but due to non-availability locally, or nationally, admission was not possible. **Had a Mental Health bed been available on the 6th June 2023, Nicola's death would not have occurred.**
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters given 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** as follows. – **Had an informal Mental Health bed been available on the 6th June 2023, and Nicola had been admitted as both she and her psychiatrist had wished, her death would not have occurred.** **I am therefore concerned in relation to the overall bed capacity for those patients like Nicola seeking informal inpatient admission.** **Nicola's case is not an isolated one.** **Evidence was heard from the Norfolk and Suffolk Foundation Trust, that on the day of the inquest itself (23rd February 2024), the availability of bed provision for informal Mental Health patients had failed to improve at all.** **The court heard that on the 23rd February 2024, the Operational Pressure Escalation Level was at its highest level (Four Black) and that at time of Nicola's inquest, in Suffolk alone, there were 20 patients on a list waiting for an informal inpatient Mental Health bed.** **The court heard, that just as on the 6th June 2023, there were no other available informal Mental Health beds anywhere else in the country.** **The facts of Nicola's case mirror those of another tragic Suffolk case, for which I produced a Prevention of Future Death Report in October 2020.** **I am therefore concerned, that any measures that may have been taken in the intervening period since October 2020, have neither adequately, or effectively, addressed this clear and continuing local and national risk of future deaths occurring.**
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken in order to prevent future deaths, and I believe you or your organisation have the power to take any such action you identify.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 2nd May 2024 I, the Senior Coroner, may extend the period if I consider it reasonable to do so.

	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;- 1. Nicola's next of kin. 2. The Chief Executive Norfolk and Suffolk NHS Foundation Trust. I am 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	 **Name: Nigel Parsley** **Date: 7th March 2024** **Appointment: HM Senior Coroner** **Jurisdiction: Suffolk**