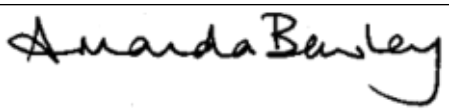
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust**
1	**CORONER** I am Amanda Bewley, Assistant Coroner, for the coroner area of Nottingham and Nottinghamshire
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 12 March 2023, I commenced an investigation into the death of Alexander Vitali Lyalushko. The investigation concluded at the end of the inquest on 15 March 2024. The conclusion of the inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** Mr Lyalushko took his own life by hanging, intending to end his life, on 2 January 2023. Mr Lyalushko died at his home address where he lived alone. My Lyalushko was a vulnerable young man with diagnoses of autistic spectrum disorder, anxiety, depression and agoraphobia. Mr Lyalushko was known to express suicidal ideation and had made suicide attempts. Mr Lyalushko had extensive involvement with mental health services throughout his life, including with Gedling Local Mental Health Team under Nottinghamshire Healthcare NHS Foundation Trust from August 2015 to August 2019, and from July 2020 to March 2022. A request for the involvement of Gedling Local Mental Health Team with Mr Lyalushko was sent to the service by Mr Lyalushko's General Practitioner on 22 November 2022. For reasons which have not been ascertainable, no action was taken in response to that request. Mr Lyalushko took his own life a little over a month later, there being no involvement of mental health services with him at the time of his death. Detailed findings as to how Mr Lyalushko came by his death are described within a written determination dated 15 March 2024, appended to this report
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving 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** are as follows:

	1. Inadequate review and incident investigation following a death Following Mr Lyalushko's death, Nottinghamshire Healthcare NHS Foundation Trust completed an SI Review by way of case note review. Following evidence which considered the content of that review, the Trust stated that the review was 'insufficient in its current form and the scope should be broadened to include the concerns raised (during the inquest hearing).' The Trust said its Patient Safety Investigation Lead would undertake a new SI Review by 26 April 2024 (6 weeks). I identified a number of deficiencies with the initial SI Review which had been undertaken in respect of Mr Lyalushko: it did not identify that a request from Mr Lyalushko's GP in November 2022 for involvement of its service with Mr Lyalushko had not been actioned; it incorrectly identified areas where improvements were required as areas of good practice; and it did not involve any level of consultation with Mr Lyalushko's family to consider whether there were any areas of concern they had which might direct elements of the review. If there is insufficient review and learning from a death that, in my judgment, adds to the likelihood of future deaths occurring in similar circumstances. I am not reassured that necessary actions to address the serious issue identified i.e. inadequate initial review and incident investigation following a death, are yet in place.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by May 20, 2024. 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 **1. Mr Lyalushko's family** I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I will send a copy of my report to the Care Quality Commission. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 25/03/2024**

	 **Amanda BEWLEY** **Assistant Coroner for** **Nottingham City and Nottinghamshire**