Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **Norfolk and Suffolk NHS Foundation Trust** **Hellesdon Hospital** **Drayton High Road** **Hellesdon** **Norwich** **NR6 5BE**
1	**CORONER** I am JACQUELINE LAKE, HM Senior Coroner for the coroner area of Norfolk
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 July 2023, I commenced an investigation into the death of Christopher Edward SIDLE aged 51. The investigation concluded at the end of the inquest on 22 March 2024. **The medical cause of death was:** 1a) Traumatic Brain Injury 1b) 1c) 2) Schizophrenia **The conclusion of the inquest was:** Mr Christopher Sidle threw himself out of a moving taxi and suffered fatal injuries. His state of mind at the time is not revealed by the evidence. There were missed opportunities to provide appropriate and timely care to Christopher and assessments carried out in respect of his mental health were inadequate.
4	**CIRCUMSTANCES OF THE DEATH** Christopher Sidle had a diagnosis of paranoid schizophrenia in 2011. This was well controlled with medication for many years with short relapses in 2014 and 2021, being resolved following swift and effective intervention by mental health services. In March 2023, Christopher started to show signs of relapse and displayed symptoms following a pattern of those displayed in previous psychotic episodes, which increased over time. He was seen by primary services and referred to secondary services.

	Following triage on 21 April 2023, by the Crisis Resolution Home Treatment Team ("CRHTT") Christopher was returned to primary care. Christopher was referred again to secondary services and an assessment completed on 10 May 2023. Christopher said he had not been taking his medication for a month. Deterioration in Christopher's mental health was recognised as the main risk and concordance with his medication needed to be achieved within three to four days. Christopher declined engagement with the CRHTT and said he would now take his medication. Christopher was allocated a Care Co Ordinator in the Community Mental Health Team on 17 May 2023 and was reviewed for several days to ensure medication concordance. These were exceptional steps taken by the Community Team due to concerns with regard to Christopher's mental health. Christopher was again referred to the CRHTT on 19 May 2023 due to concerns regarding his mental ill health and displaying signs of psychosis and a pattern of previous psychotic symptoms. He was triaged and an assessment was undertaken on 20 May 2023. Christopher attended with his bag packed and was willing to be admitted for inpatient treatment. Evidence was heard this would not be possible in any event due to lack of available inpatient beds at that time. Christopher again said he was not taking his medication. Christopher was not taken on and again returned to the Community Team. The assessment was inadequate and psychotic markers were underestimated and/or missed. This was a missed opportunity to provide appropriate care and treatment to Christopher. Later that evening Christopher went missing from home and was later returned by police. From 22 May 2023, Christopher was monitored on a daily basis with regard to his medication for 7 to 10 days by the Community Team which they would not usually do, pending his being seen by a Consultant Psychiatrist. Christopher took his medication during this period. A recovery plan was completed and put in place by the Community Team by 1 June 2023, in which the crisis plan states: Deterioration in mental wellbeing - "It may be hard to notice, people should try to use their gut instincts, especially if they know me" and "Take over my responsibilities", "Check my medication adherence" and "I may not know when help is needed and would appreciate teams making decisions." Christopher agreed to see a Consultant Psychiatrist and to discuss a depot injection and was seen on 6 June 2023. A deterioration in his mental health was noted. Christopher declined depot injection and said he will take his oral medication. Christopher was seen by the Community Mental Health Team and arrangements were made for him to be seen in two to three weeks' time to review his medication. On 28 June 2023, Christopher showed psychotic symptoms witnessed by his family and then the community team and a referral was made to the CRHTT for possible admission to hospital. Christopher was accepting of the referral and was present when this was triaged. That evening Christopher went missing again and was returned home by police. Requests were made by his family for Christopher's history and ability to mask his symptoms be recorded in his notes prior to the Crisis assessment. The assessment was carried out on 29 June 2023 without discussion within the team, without reading Christopher's records other than the triage document and the previous assessment note, due to insufficient time being allowed by the Team prior to the assessment. The assessment continued without knowledge of Christopher's history and his ability to mask symptoms. There was no formal monitoring of the assessment which was allocated on the basis of availability of assessor rather than experience or suitability. This was the assessor's first lone assessment. Christopher was not taken on by the CRHTT and returned for community care. The assessment was inadequate and was a further missed opportunity to provide appropriate inpatient care to Christopher, which more than minimally contributed to his death.

	Following a telephone conversation with Christopher's family again providing relevant information with regard to Christopher's history and mental health, no further action was taken and the decision not to take Christopher on by the team remained. This was a further missed opportunity to provide appropriate care and treatment to Christopher. Concern was raised in the Community Team on the morning of 30 June 2023 that Christopher had not been taken on by the Crisis Team. No immediate action was taken to ensure Christopher was re-assessed and this was a missed opportunity to provide immediate appropriate care to Christopher. A Mental Health Act assessment was requested by Christopher's family. A discussion by the allocated assessor with the community team was requested and this was not responded to. On 1 July 2023, Christopher ordered a taxi to take him to an acute hospital. En-route while the taxi was travelling at approximately 30 mph Christopher jumped out of the taxi into the roadway. Christopher was taken to Addenbrookes hospital where he was found to have suffered life threatening head injuries. Life sustaining therapies ceased on 4 July 2023 and Christopher died. The evidence does not reveal whether Christopher had intention or if so, what that intention was, at the time of jumping out of the taxi.
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. It is clear that the NSFT have treated the circumstances surrounding Christopher's death seriously and have carried out an internal investigation, made recommendations and have put in place steps to prevent future deaths. However, there do remain outstanding matters of concern. The **MATTERS OF CONCERN** are as follows: 1. Despite additional face to face training being made available to the CRHTT, witness evidence was heard which does not reflect the findings of the investigation and does not recognise the need for a full and proper assessment and the need not to accept a service user's response to questions raised. 2. There remains a lack of understanding amongst the CRHTT with regard to the scope and limitations of other services available within the community team. 3. There remains a lack of understanding with regard to assessing a person's mental capacity to make decisions and to fully and properly record the rationale for making decisions. 4. Support provided by FACT is usually carried out by telephone and will in some circumstances not be sufficient to recognise ongoing concerns, for instance with regard to medication concordance. 5. Important emails were not circulated to relevant personnel within the CRHTT. The evidence remains unclear what happened to the emails and why they did not reach the appropriate member of the team. 6. A person can be identified at triage risk assessment as being in need of an "immediate response, within 4 hours" but an assessment is then arranged for within a 24-hour period. 7. Evidence was heard of a nationwide shortage of inpatient mental health beds. Action has been taken by NSFT in an effort to minimise impact, but this does remain an ongoing concern.

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 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: [redacted] (Sister) via Ashtons Legal I have also sent it to: Department of Health/Secretary of State CQC HSIB Healthwatch Norfolk NHS England & NHS Improvement who may find it useful or of interest. 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 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 March 2024**  **Jacqueline Lake** **Senior Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH