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:** **1 [redacted], Chief Executive Officer, Norfolk & Suffolk NHS Foundation Trust**
1	**CORONER** I am Peter TAHERI, Assistant 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 24 April 2023 I commenced an investigation into the death of Paul David TEMPLETON aged 65. The investigation concluded at the end of the inquest on 21 February 2024. The conclusion of the inquest was one of: Suicide The medical cause of death was confirmed as: 1a Hypoxic Brain Injury 1b Asphyxiation 1c
4	**CIRCUMSTANCES OF THE DEATH** The Jury's answer given in the Record of Inquest to how, when and where the deceased came by his death was as follows: "Paul Templeton came by his death due to the termination of life support on 20th April 2023 at Ipswich Hospital. Paul died at 5:35am. The circumstances leading to Paul's admission to hospital where he eventually died began on the morning of 14th April 2023 at Woodlands, Willow Ward. Between the hours of 8:39am and 9:18am Mr Paul David Templeton [redacted] cause asphyxiation. Mr Paul Templeton's mental state deteriorated during 2022 to the point at which he was severely malnourished and dehydrated. This led to hospitalisation for kidney injury and later transferral to Woodlands under section 2 of the Mental Health Act. Initial and all subsequent assessments seriously fail to recognise that Paul's prolonged choice not to eat or drink were in fact indications of `action` to end his own life and therefore he should have been considered as a suicide risk."
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:
(brief summary of matters of concern)

In the words of the Jury: "Initial and all subsequent assessments seriously fail to recognise that Paul's prolonged choice not to eat or drink were in fact indications of 'action' to end his own life and therefore he should have been considered as a suicide risk."

Action is needed to prevent future failure to recognise (a) when the prolonged choice of a patient detained under the Mental Health Act not to eat or drink should be regarded as an action to end their own life; and (b) when such a patient's prolonged choice not to eat or drink should be recognised as elevating that patient's suicide risk (including of suicide by means other than malnourishment).

At the conclusion of the Inquest, after the Jury had returned the completed Record of Inquest, I asked the Norfolk & Suffolk NHS Foundation Trust ('NSFT') to assist me with written information to inform me of what action is being taken to prevent future deaths related to the "serious failures" in risk assessment as to suicide risk identified by the Jury within their answer to how Mr Templeton died.

I am grateful for the letter addressed to me, dated 29th February 2024, from the Deputy Chief Executive & Chief People Officer of NSFT. However, the contents of this letter did not allay my concern in this regard. The letter reiterated factual points that were substantially placed before the Jury in evidence. The letter then set out what appears in my view to be the central point that NSFT wished to make:

"At no point prior to or during Mr Templeton's admission, did he present as a risk of self-harm or suicide other than through food or fluid restriction and on that basis there was no evidence to include previous history, recorded thoughts, ideation or plans to identify a risk of ligature. To implement a more restrictive environment upon Mr Templeton without evidence to do so would amount to a blanket restriction in breach of Regulations 13 and 17 of the Health and Social Care Act…"

This response does not grasp, engage with, or show reflection in light of the Jury's finding. It therefore does not allay my concern that circumstances creating a risk of further deaths will occur, or will continue to exist, in the future. The Jury's finding was precisely that Mr Templeton did present as a risk of self-harm or suicide other than through food or fluid restriction – and that NSFT failed to recognise this risk as it was expressed by way of Mr Templeton choosing not to eat or drink. Although NSFT's letter argues that implementing a more restrictive environment without evidence to do so would amount to an impermissible blanket restriction, the Jury's finding was precisely that there was evidence (namely the prolonged choice not to eat and drink) that should have been recognised as being action taken to end his own life and therefore implying an elevated suicide risk.

NSFT's letter goes on to draw my attention to three actions for improvement that are underway or in process. Firstly, "The inpatient clinical team to improve the quality and consistency of their psychological, food and fluid recording and discussions of the same within MDT recording." While improved discussions regarding food and fluid recording might conceivably trigger recognition of when a refusal to eat or drink indicates suicidal ideation and action, merely recording and discussing food and fluid intake does not necessarily entail recognising when refusal to eat or drink reflects greater suicide risk. This action on its own does not appear to raise awareness among those conducting suicide risk assessments that a prolonged refusal to eat or drink may reflect an elevated suicide risk, as recognised by the Jury. It may be that review is required on the learning, training, and / or guidance given to assist those undertaking suicide risk assessments in relation to how they should interpret a prolonged refusal to eat or drink and the risk of suicide arising from such action.

	Of course, it is not for the Coroner to recommend what action is required or to make specific remedial recommendations. Secondly, "The Community and Crisis team were identified as requiring improvement by ensuring routine weighing of patients to provide baseline and discussing and sharing the same…". Thirdly, "The Crisis team was identified as requiring improvement in respect of ensuring physical health is monitored and considered within assessments…" Neither of these actions address the particular concern highlighted by the Jury's finding, not least as the serious failures identified by the Jury took place in Woodlands and not in the Community or Crisis teams.
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 31, 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] 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	**Dated: 05/04/2024** Taheri **Peter TAHERI** **Assistant Coroner for Suffolk**