	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) **2.** South Tyneside Council
1	**CORONER** I am Leila Benyounes, Assistant Coroner for the coronial area of Gateshead and South Tyneside
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 20/07/21 an investigation was commenced into the death of Christopher Paul Vickers. The investigation concluded at the end of the inquest on 29/02/24. The conclusion of the inquest was: The Deceased, who suffered a worsening of symptoms in respect of his mental health conditions and ADHD, ended his life during an acute on chronic episode. The medical cause of death was: 1a) Pressure on the neck from a ligature
4	**CIRCUMSTANCES OF THE DEATH** The Deceased had received assessment and treatment from primary and secondary care in relation to his mental health conditions and ADHD and had been assessed by the local authority in early 2020 and found to have specific needs. From the end of 2020 there was a worsening of the deceased's symptoms and behaviours. The deceased reported that the impact of the COVID-19 pandemic had affected his mental health and ADHD and was a factor in exacerbating his symptoms of anxiety and intrusive thoughts.

	From June 2021 there was a further escalation of the Deceased's behaviours and risks of self-harm and harm to others, resulting in an increase in referrals and contacts to agencies by the Deceased's family and other professionals for support, assessment, and treatment. The Deceased underwent triage and full assessments by the crisis team and a review by the ADHD team, which ultimately resulted in a referral to and assessment by the community treatment team, who agreed to provide treatment on 25/06/21 and the Deceased was placed on their waiting list. The Deceased was prescribed medication to address anxiety and lack of sleep. Despite the known escalation of behaviours, the increase in the risks to self and to others, and the fact that the Deceased was open to various agencies and services, there were multiple repeated missed opportunities by different organisations to instigate a safeguarding referral for formal safeguarding supervision, or to convene a or multi-disciplinary or multi-agency meeting to co-ordinate the Deceased's care with the provision of a shared care plan. The Deceased was found on 18/07/21 with a ligature around his neck and death was certified on 18/07/21 at 18.06.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence 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. There were multiple repeated missed opportunities to co-ordinate the Deceased's care with the convention of multi-disciplinary and multi-agency meetings despite known escalating risk. 2. There were multiple repeated missed opportunities to make safeguarding referrals for formal safeguarding supervision from the safeguarding adult public protection team despite known escalating risk to self and to others. There remains a risk that future deaths could occur as the missed opportunities were significant and multiple and relate to clear processes and policies that were not followed. Current action that has been undertaken does not address my concerns.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 25 April 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, the Family of Mr Vickers and Marsden Road Health Centre. 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	**LEILA BENYOUNES** **Assistant Coroner for Gateshead and South Tyneside** **29/02/24**