Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive of Berkshire Healthcare NHS Foundation Trust**
1	**CORONER** I am HEIDI J CONNOR, Senior Coroner for Berkshire for the coroner area of Berkshire
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. It is important to note the case of R (Dr Siddiqui and Dr Paeprer-Rohricht) v Assistant Coroner for East London. This case clarifies that the issuing and receipt of a Regulation 28 report entails no more than the coroner bringing some information regarding a public safety concern to the attention of the recipient. The report is not punitive in nature and engages no civil or criminal right or obligation on the part of the recipient, other than the obligation to respond to the report in writing within 56 days.
3	**INVESTIGATION** I conducted an inquest into the death of Mohammed Ahmed Hany Ellaboudy (known to the family as Moh), which concluded on 24th of April 2024. I recorded a narrative conclusion as follows: Mohammed Ellaboudy died after placing himself in front of a moving train. His actions were deliberate, but his mental state and capacity to form intention are unclear. The family requested me to refer to the deceased Moh. I will reflect that in this report.
4	**CIRCUMSTANCES OF THE DEATH** Moh was a 34 year old man who had been diagnosed with paranoid schizophrenia. He had a significant mental health history, having been admitted to psychiatric hospitals in 2011, 2017 and 2020, before his final admission in 2022. He had also been an inpatient in psychiatric units abroad. There had been previous attempts by Moh to take his own life. Previous relapses in his mental health state had been associated with Moh declining to take his anti-psychotic medication. He was receiving Aripiprazole via depot injection. Moh stopped taking this medication again in December 2021, and he was detained under the Mental Health Act in July 2022, under Section 2 of the Mental Health Act 1983. Moh was discharged from Prospect Park Hospital, Reading Berkshire in August 2022. A discharge summary was sent to his GP practice at that time, but there was no further correspondence from the mental health trust to the GP until the end of March 2023. The inquest focused on the time from when Moh first stopped taking his anti-psychotic medication again (March 2023), to the time of his death (8th September 2023). During that time period, there were two telephone calls to his GP, and a telephone call with the practice mental health nurse.

	Looking at the same period of time from the mental health team's perspective, there were two appointments with a specialist doctor (both by telephone), and two brief telephone conversations with community mental health team nurses. By March 2023, the mental health teams knew that Moh was no longer complying with his medication. They knew his previous history of relapses when coming off medication. They knew that Moh was not working. These had been clearly described in a previous discharge summary as relapse signs for Moh. There was no face to face appointment to assess other potentially important risk factors, such as self neglect. We heard evidence that Moh himself insisted on not having face to face appointments as he feared being detained under the Mental Health Act again. I accepted evidence from the psychiatry witness that it is sometimes better to have at least some contact with a patient, rather than pressurising them and the patient refusing to have any contact at all. Whilst this may be true in practical terms, there was no documented rationale in this sense. It was accepted by the trust that there was a distinct lack of proactivity, rather than a conscious plan, particularly in the last months of Moh's life. There were matters which troubled me about Moh's case. He was unwell enough to be detained under the Mental Health Act in July 2022. By then he had had multiple previous relapses and admissions and attempts to end his own life. After being discharged from Prospect Park Hospital, he was under the auspices of a care co-ordinator, who largely spoke to him by telephone. It is very stark to note that the last face to face contact he had with any mental health professional (after being discharged from Prospect Park Hospital in August 2022) was February 2023, when he went for his last depot injection. He had no face to face appointment after that, and he died 7 months later. I was also concerned to note that the last multi-disciplinary team discussion about Moh was in May 2023. A later MDT would have been an opportunity for Moh's case to be considered in terms of alternative contact methods and more comprehensive assessment of risk. The evidence showed that Moh had expressed a clear wish not to have face to face appointments for fear of being detained under the Mental Health Act again. A number of other relapse signs were also present and likely to be escalating in the final months of his life.
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. I am concerned about whether systems are in place for sufficiently robust care coordination for patients who have been discharged from a mental health setting, particularly in the context of detained/recently detained patients. 2. Reliance on telephone rather than face to face appointments. 3. Regularity / thresholds for MDT discussions. 4. Absence of a clear route for family to report concerns, even where a patient does not wish confidential information to be given to their family. 5. Policy / expectation for correspondence with primary care, particularly in the time after discharge from hospital.
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 June 25, 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 Moh's family. I have also sent this report to the following recipients, who have an interest in this matter: 1. Legal representative for Moh's GP. 2. Legal representative for Berkshire Healthcare NHS Foundation Trust. who may find it useful or of interest. 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: 30/04/2024**  **HEIDI J CONNOR** **Senior Coroner for Berkshire for Berkshire**