	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) EAST MIDLANDS AMBULANCE SERVICE NHS TRUST** **(2) NHS NORTHAMPTONSHIRE INTEGRATED CARE BOARD**
1	**CORONER** I am Jonathan Dixey, assistant coroner, for the coroner area of Northamptonshire.
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 5th April 2023 an investigation was commenced into the death of Liam Paul McCarlie. On 5th June 2024 I concluded the inquest into Mr McCarlie's death. The conclusion of that inquest was a narrative conclusion: Liam Paul McCarlie died by suicide. From 15 February 2023 there was an insufficiently clear plan to support proactively Mr McCarlie's mental health whilst he waited for formal assessment for suitability for the Structured Clinical Management programme. This possibly contributed to his death. On 1 April 2023 there was a significant delay in an ambulance attending upon Mr McCarlie following an emergency call. This delay was caused by an increased demand on the ambulance service. This delay contributed to Mr McCarlie's death. The medical cause of death was: 1a Hanging
4	**CIRCUMSTANCES OF THE DEATH** At around 23.23 on 1st April 2023 Liam Paul McCarlie was found by paramedics suspended by a ligature [redacted]. Mr McCarlie was not breathing, had no pulse and had a Glasgow Coma Scale score of 3/15. His heart rhythm was asystole. Earlier that evening he had exchanged text messages in which he had expressed an intention to take his own life. At around 17.52 his father and step-mother contacted the ambulance service. The call was assessed as requiring a 120 minute 90th centile response time. Paramedic led Double Crewed Ambulances had been allocated at 20.29 and 22.08 however both were stood down and reallocated to attend higher priority calls. At the time, the local ambulance service was experiencing a prolonged and significant increase in calls resulting in delays: a critical safety plan was in operation. A third paramedic led Double Crewed Ambulance was allocated at 22.50. That ambulance arrived [redacted] at 23.11, i.e. 5 hours and 19 minutes after the initial call and therefore significantly outside of the 90th centile for a call of this kind. Had the ambulance service arrived within the required response time, it would have done so at a time when Mr McCarlie was still alive. The last recorded call from Mr McCarlie was at 19.26 (a call lasting 2 minutes). The last recorded text message was

	sent by Mr McCarlie at 20.18. Death was confirmed at 00.33 on 2nd April 2023. In early February 2023 Mr McCarlie's mental health deteriorated significantly. He was assessed by various mental health professionals, including a consultant psychiatrist. Mr McCarlie had previously attempted suicide in July 2021; following this he took anti-depressant medication until February or March 2023. On 15th February 2023 Mr McCarlie was identified as presenting with traits which were highly indicative of Emotionally Unstable Personality Disorder. He was referred to the Structured Clinical Management ("SCM") programme. At the time of his death Mr McCarlie had not been formally assessed for suitability within the SCM programme.
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. – During the inquest I heard evidence from the Senior Quality Manager for Coroner Services at the East Midlands Ambulance Service NHS Trust ("EMAS"). She explained that some Integrated Care Boards had introduced a scheme whereby a mental health nurse would accompany a paramedic in a car and in appropriate cases would be dispatched to a patient for the purposes of meeting both their physical and mental health needs. The NHS Northamptonshire Integrated Care Board ("the Northamptonshire ICB") did not adopt this scheme. Instead, the Northamptonshire ICB have introduced a mental health nurse located within the Emergency Operations Centres ("the EOC") for the purpose of providing advice and, in appropriate cases, despatch from the EOC. I was told that members of EMAS have access to General Practitioner records held on SystmOne. EMAS does not have access to mental health records. In respect of Leicestershire, Lincolnshire and Nottinghamshire those records are held on a system called RiO. In respect of Northamptonshire and Derbyshire those records are held on SystmOne. I was told that there was no technical reason why EMAS staff (especially the mental health nurse located in the EOS) could not access a patient's mental health records if held on SystmOne. There are such technical reasons why EMAS staff do not have access to RiO (an entirely different database). A data sharing agreement is likely to be needed as may a particular patient's consent. I am concerned that notwithstanding the recognition of the desirability for specialist mental health input, those mental health professionals within the EOC do not presently have access to records which may have been produced by the community mental health team. That is notwithstanding that the principal database used by the provider of community mental health treatment in Northamptonshire (the Northamptonshire Healthcare NHS Foundation Trust) is one to which EMAS does presently have access. Such information may be relevant to, for example, whether the patient has a history of suicidal ideation or attempts. That information may in turn be material to the triage and dispatch of ambulance resources.
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 20th August 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. The family of Liam McCarlie. 2. Northamptonshire Healthcare NHS Foundation Trust. 3. The Greens Norton Medical Practice. 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	**24th June 2024** **JONATHAN DIXEY**