Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Secretary of State Department of Health and Social Care**
1	**CORONER** I am Nigel Parsley, Senior 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 1st August 2023 I commenced an investigation into the death of **Gemima CHRISTODOULOU-PEACE** The investigation concluded at the end of the inquest on 17th July 2024. The conclusion of the inquest was that the death was the result of:- **Gemima died as the result of a suspension hanging, but there is insufficient evidence to show that at all material times she intended her death, due to impulsivity associated with her diagnosed mental illness, and the intoxicating effect of** [redacted] The medical cause of death was confirmed as: **1a Suspension Hanging**
4	**CIRCUMSTANCES OF THE DEATH** **Gemima Christodoulou-Peace was declared deceased on Monday 31st July 2023 at** [redacted] **, in Suffolk.** **Gemima had been found inside the premises, suspended by her neck from a ligature. A subsequent post-mortem examination identified marks on Gemima's neck consistent with death by suspension by a ligature.** **Police investigations of digital media evidence identified on a balance of probabilities, that Gemima died on, or about the 26th July 2023.** **Gemima was known to suffer with her mental health (Emotionally Unstable Personality Disorder, anxiety, and depression), had previously taken overdoses of medication, and had previously been admitted to hospital mental health units.** **At the time of her death Gemima was found to have a high level of** [redacted] **in her system, which can induce feelings of detachment, confusion, altered perception of space and time, and panic attacks.** **In addition, in May 2023 Gemima received a repeat prescription of a drug called**

	Montelukast, which in rare cases is known to increase suicidal behaviour. It is however not known when Gemima last took this drug, and none was found in Gemima's system at the time of her death.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters given 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** as follows. – 1. **Currently a treating clinician would need to undertake independent review on every prescription medication a patient is taking, to identify if any of those medications have a reported side-effect of increasing suicidal behaviour.** **For some medications this side-effect is very rare, so it is highly unlikely that a treating clinician could know all the medications identified as having a risk of increasing suicidal behaviour.** **At present there is no single reference point which a treating clinician can access, to readily and quickly identify if a patient is on a prescribed medication which is known to increase suicidal behaviour in some patients.** 2. **There are currently only a limited number of calls going into the Norfolk and Suffolk Foundation Trust which are being recorded.** **As such, should the clinician taking the call suddenly need to be absent (e.g. sudden ill health, domestic emergency, etc) and therefore cannot provide details of the call, there is no way any other treating clinician can respond to needs of that patient, or address any risks to that patient identified in that call.** **In addition, without a recording of calls there is no opportunity to review cases were there may be some doubt as to what a patient or clinician has said, or when a different clinician wishes to hear the patient themselves to independently assess the patients presentation, or for a Multi-Disciplinary Team to review the contents of that call.** **As many interactions between the NSFT and patients are telephone based, the availability of accurate recording of those conversations, and increased accessibility to them, would improve patient safety.** **3. Gemima first reported a decline in her mental health in March 2023 and requested to be put back onto her previous medication. Gemima's GP could not do this without input from a prescribing mental health practitioner, so a referral to secondary Mental Health Services was made. Gemima's March request did not result in her obtaining an appointment with a prescribing mental health practitioner, at that time.** **Gemima reported her continuing low mood to her GP again on the 3rd July 2023, but as she had been referred to a Wellbeing Team, was told to contact NHS 111 Option 2 if she was 'in crisis'.**

	On the 19th July 2023 Gemima told her GP her anxiety was 'through the roof' so an urgent referral to the Mental Health Services was made. **Gemima was assessed over the telephone six days later on the 25th July 2023, and was offered crisis support which she declined, as Gemima wanted a medication review with the mental health team she had seen previously.** **On the 25th July 2023 a risk assessment was undertaken with Gemima, and using the RAG (Red, Amber, Green) system, Gemima was deemed to be an 'Amber', and therefore 'moderate' risk.** **The court heard that any case risk rated 'Red', had a target response time of 4-72 hours (if the patient was in crisis) and 7 days for other 'Red' cases. Any case risk rated 'Amber' had a target response time of 2 to 4 weeks, and any case rated 'Green' had a target response time of 28 days.** **All treating clinicians who gave evidence in Gemima's case said 'in an ideal world' resources would allow for much more timely interventions than those currently possible, especially those cases rated 'Red' or 'Amber'.** **Although Gemima herself had recognised the need to be back on her mental health medication, resource pressures meant that at the time of her death, she had still not seen a treating mental health practitioner who could prescribe her previous mental health prescription.** **Gemima's treatment assessment was booked for the 8th August 2023, 14 days after her tragic death.**
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken in order to prevent future deaths, and I believe you or your organisation have the power to take any such action you identify.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by September 16, 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. Gemima's next of kin. 2. The other listed IP's in this case. 3. Haringey Social Services I am 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

9	**Dated: 22/07/2024**  **Nigel PARSLEY** **HM Senior Coroner for** **Suffolk**