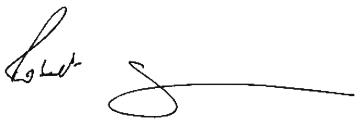
Coroner Service
West Sussex, Brighton & Hove

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 Chief Constable of Sussex Police** **2 CEO Sussex Partnership NHS Foundation Trust (SPFT)**
1	**CORONER** I am Robert SIMPSON, Assistant Coroner for the coroner area of West Sussex, Brighton and Hove
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 11 August 2022 I commenced an investigation into the death of Ryan Louis Ouslem aged 34. The investigation concluded at the end of the inquest on 05 September 2024. The conclusion of the inquest was that: On the 1st August 2022, Ryan Louis Ouslem died by [redacted] poisoning at the rear top floor flat, [redacted]. On 29th July 2022 Ryan hired [redacted] and he hired [redacted] on 1st August 2022. He then took additional steps of [redacted], writing a suicide note and bank details and blocking entry to the property with large speakers. He subsequently ran the [redacted] with the intention of ending his life by [redacted] poisoning.
4	**CIRCUMSTANCES OF THE DEATH** Ryan lived alone. On Friday 29/07/2022 he put a post on Facebook which raised concerns for his welfare and indicated that his flat was not safe to enter. Police and fire services atttended and forced entry finding Ryan alive. He denied any ongoing intent to harm himself. The police offered Ryan a call from a mental health service nurse the following day and left the scene. On Monday 01/08/2022 Ryan's mother and partner could not get a response from Ryan. The police and fire services attended and forced entry again. Ryan was found deceased on his bed.
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) <u>Police</u> During the evidence of the PC who attended on the 29/07/22 she informed the court that: • She had had some suicide awareness training when she commenced her role as a police officer some 7 years ago but could not remember it. • She believed that she had had some training in respect of her powers under s.136 of

	the Mental Health Act 1983 but could not say when this was. • She demonstrated in her evidence that she did not fully understand when the police powers under this section of the Mental Health Act could be exercised. • She was not aware of the suicide and mental health information available on the Crew Mate App which all officers had access to. • She was a coach for newly qualified officers. • She had not taken part in any joint training with mental health service providers. • She did not make enquiries at the scene that might have been expected, for example, reading the Facebook message in question, asking questions about why the flat was not safe to enter & seeking information from Ryan's mother who was present at the time. Sussex police were afforded the opportunity to provide information about their training provision after the inquest. I have considered this information and I still have concerns. The police have stated that mental health training has been a particular focus for some time. Despite this an officer with a training role was unable to explain what training that was and when they had received it. It appears to me from the police response that whilst mental health training and resources are offered to existing officers it is still not mandatory. I note that new officers joining will be undergoing accredited mental health training but this has not yet been rolled out. Whatever training and resources have been provided I remain concerned it has not been effective and is not repeated as often as may be required to provide officers with the necessary skills and knowledge. <u>Mental health services & joint working with the police</u> The inquest heard evidence from a Street Triage practitioner who was embedded with the police on the 29/07/22. She explained that they are reliant on the police to share relevant information, for example from the police CAD system. In this case not all relevant information was passed to the mental health practitioner in a timely manner. An SPFT witness stated that it was not for them to provide training to the police and that she had not been on any cross-service training. I was informed that a new system of working with the police is being introduced this will be called the 'Rapid Response Service' and mental health workers will no longer be embedded with the police. SPFT has provided me with the way the new system is anticipated to function and this has been helpful in understanding the changes. No policy documents yet exist for this system and an SPFT witness told me that how information is to be shared between them and the police service is yet to be ironed out. Some of this service will not be dissimilar to the Street Triage service. I am concerned because this new approach under the 'Right Care, Right Person' policy will still need police officers to understand mental health issues in order to know when to pass matters on for mental health services to deal and what information to provide. Despite the significant change of working arrangements there does not appear to have been any joint training undertaken; nor am I informed that any is planned. I am concerned that the importance of sharing all relevant information will not be understood unless each organisation understands what information to provide to the other or what questions to ask.
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 November 21, 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 Ryan Ouslem** **West Sussex Fire & Rescue Service** I have also sent it to n/a who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 24/09/2024**  **Robert SIMPSON** **Assistant Coroner for** **West Sussex, Brighton and Hove**