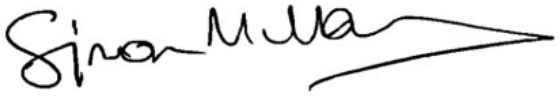
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Secretary of State for Health and Social Care** **2. The Chief Executive, NHS England** **3. The Chief Executive, Cambridgeshire and Peterborough Integrated Care Board**
1	**CORONER** I am SIMON MILBURN, Area Coroner, for the coroner area of Cambridgeshire & Peterborough
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 4 April 2022 I commenced an investigation into the death of DECLAN GORDON GERARD MORRISON, who died on 2 April 2022, aged 26. The investigation concluded at the end of the inquest before me and a jury on 3 October 2024. The conclusion of the Jury was:- Medical cause of death:- 1a) Traumatic acute on chronic subdural haemorrhage (operated); Conclusion:- Declan died from head injuries caused by him banging his head whilst he was detained at the Section 136 Suite at Fulbourn Hospital under Section 2 of the Mental Health Act.
4	**CIRCUMSTANCES OF THE DEATH** Declan was just 26 years of age at the date of his tragic death. He had diagnoses which included ASD, ADHD and Learning Disability. Declan was largely non-verbal and required 24-hour residential care. His needs were highly complex. He lacked mental capacity to make decisions in his own best interests. Between 2014 and March 2022 he resided in private placements sourced by Cambridgeshire County Council's Learning Disability Partnership. Declan moved into his final placement in May 2021 after the previous placement had become unable to meet his needs. By the end of 2021(latest) it was agreed by all the professionals involved in his care and the private care provider that this placement was also unable to meet Declan's complex needs. His mental health and behaviour began to deteriorate as a result. The private care provider felt that they could not consequently keep Declan (and other residents) safe. Despite attempts to find Declan an alternative appropriate placement CCC's LDP could find nothing available either locally or nationally. Demand for such placements outstrips supply – providers are effectively able to 'pick and choose' who they offer placements to.

	Declan's mental health and behaviour declined further and as the result of an incident on 8 March 2022 whereby he was detained under Section 136 of the Mental Health Act. Declan was taken to Addenbrookes Hospital Emergency Department in Cambridge as a place of safety where he was then further detained under Section 2 of the Mental Health Act. There was no suitable hospital placement available and so Declan was taken to the Section 136 Suite at Fulbourn Hospital in Cambridge. The evidence was clear – the Section 136 Suite is suitable only as a temporary placement for those suffering an immediate mental health crisis. It is/was not a suitable facility for longer term detention and or for someone with Declan's complex needs. Staff there were not appropriately trained to care for him Whilst it was hoped that Declan's placement would be only temporary once again both local and national searches for an appropriate alternative were unsuccessful. Declan's mental health declined further in the Section 136 Suite. His behaviour became more agitated and disturbed. As a result, he engaged in self-harming behaviours including blows to the head. He was found unresponsive on 18 March 2022 having suffered catastrophic brain injuries. Tragically Declan died at Addenbrookes Hospital in Cambridge on 2 April 2022. The Integrated Care Board for Cambridgeshire & Peterborough funded a bespoke residential 'Crisis Service' in November 2023. It remained open for 38 weeks (during which it operated at 98% capacity) before funding was withdrawn. Had such a placement been available to Declan it would potentially have avoided the need for him to be detained under the Mental Health Act.
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) The evidence revealed that there is currently a widespread shortage of available placements for someone with Declan's complex needs both in the community and within the NHS. (2) Once it was clear that Declan's community placement had broken down in late 2021 no suitable alternative could be found. This resulted in a decline in Declan's mental health and behaviour which ultimately necessitated his detention under the Mental Health Act. There was then nowhere suitable to detain him under Section 2 of the Mental Health Act. (3) The Section 136 Suite was completely inappropriate. Declan's mental health and behaviour declined further and ultimately this resulted in his death. (4) Declan was in crisis for several months – the facilities were simply not available in the community and once detained, in order to prevent his death.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 **18 December 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) Declan's Family/Legal Representatives 2) Cambridgeshire County Council 3) Cambridgeshire & Peterborough NHS Foundation Trust 4) Caretech Holdings 5) Cambridgeshire Constabulary 6) Cambridge University Hospitals Trust. I am also under a duty to send the Chief Coroner a copy of your response and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other 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	 **Mr Simon Milburn** **H M Area Coroner for Cambridgeshire and Peterborough** **23 day of October 2024**