REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Secretary of State Department of Health and Social Care** **The Chief Executive Norfolk and Suffolk NHS Foundation Trust,** **Suffolk County Council, Head of Social Work Mental Health Services**
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 18th March 2024 I commenced an investigation into the death of **Nigel Hutton HAMMOND** The investigation concluded at the end of the inquest on 8th October 2024. The conclusion of the inquest was that the death was the result of: - **Suicide, whilst the balance of his mind was disturbed**. The medical cause of death was confirmed as: **1a Left Middle Cerebral Artery infarction, Traumatic Brain Injury** **2 Depression, Lymphoma**
4	**CIRCUMSTANCES OF THE DEATH** **Nigel Hammond's death was verified at 10:20 on 14th March 2024, at the Addenbrooke's Hospital, Cambridge.** **On the 11th March 2024 Nigel fell from [redacted] at his home address.** **An ambulance was called, and Nigel was initially taken to the Ipswich Hospital but was transferred to the trauma centre at Addenbrooke's hospital due to the extent of his injuries.** **Nigel succumbed to the injuries received in the fall, three days later.** **Nigel had suffered with his mental health for a protracted period, and it is more likely than not that his fall from the window was a deliberate attempt to end his life.**
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. **In late 2018 Nigel became seriously mentally unwell and was admitted to a Mental Health Unit, under the Mental Health Act provisions, for a period of 3 months. Whilst admitted, Nigel was diagnosed with advanced lymphoma (a lymphatic cancer) and upon discharge from the Mental Health Unit spent a further 3 months in hospital being treated for this.**

2. **Nigel found his Mental Health Unit admission very traumatic and was described as 'terrified' of the thought of ever being admitted again.**

3. **Upon his release, his family, carers, Mental Health Home Treatment team, worked together to provide exemplary care for Nigel, whose health stabilised and in 2020 his care was transferred back to his own General Practitioner.**

4. **Nigel remained well until Friday 8th March 2024, when due to his decline in mental health he was taken to see his GP, and on the 9th March 2024 Nigel was prevented by family intervention from ending his life by [redacted].**

5. **This incident led to Nigel's family speaking to the on duty Authorised Mental Health Professional (AMHP) from the Suffolk Emergency Duty Service Team, on the evening of 9th March 2024. An AMHP is a mental health professional approved by a local social services authority to coordinate the mental health assessment and admission to hospital, of individuals requiring admission under the Mental Health Act provisions**

6. **In evidence, the court heard that the AMHP, in line with Nigel's family and his own wishes, agreed that an admission to hospital would not be in Nigel's best interest. The AMHP identified that the successful home treatment regime previously in place would be the ideal care package for Nigel. This arrangement would also be consistent with the 'least restrictive principle' which surrounds the application of Mental Health legislation.**

7. **That said, although Nigel did not meet the criteria for immediate admission, the AMHP believed Nigel was mentally very unwell, and in need of immediate support. The court heard that such support would be available within a 4-hour target time, from the emergency Crisis Resolution and Home Treatment Team.**

8. **However, the court was told that an AMHP, despite their role in the coordination of the mental health assessment and admission to hospital of a patient, were not permitted to make direct referrals to the emergency Crisis Resolution and Home Treatment Team.**

9. **The court heard that the normal route for such referrals was via the GP Surgery, or primary care Mental Health Nurse, neither of whom in Nigel's case would have been available before 08:00 on Monday 11th March 2024. Nigel's fall which led to his death, occurred at 06:25 that morning.**

	10. **I am concerned, as had the AHMP in Nigel's case been able to directly refer him to the Crisis Resolution and Home Treatment Team on the 9th March 2024, mental health professionals would have attended, and been able to provide additional support, advice and potentially additional treatment for Nigel, in all likelihood preventing his 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 4th December 2024 I, the Senior Coroner, may extend the period if I consider it reasonable to do so. 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. Nigel's next of kin. 2. Nigel's GP 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. She may send a copy of this report to any person who she 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	**9th October 2024** **Nigel Parsley**