REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Chief Executive, Nottinghamshire Healthcare Trust (NHCT) The Chief Executive, East Midlands Ambulance Service (EMAS) The Royal College of General Practitioners
1	**CORONER** I am Miss Sarah Wood, Assistant Coroner, for the coroner area of Nottinghamshire.
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 the 3rd of April 2025, I commenced an investigation into the death of Mr Gunaratnam Kannan. The investigation concluded at the end of the inquest on the 30th of October 2025. The conclusion of the inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** On the 18th of March 2025 at 11.14am East Midlands Ambulance Service (EMAS) received an emergency call from Mr Kannan's son in law. He reported that Mr Kannan was awake and breathing and that he had taken an overdose of tablets. At 11.29am EMAS dispatched a paramedic led double crewed ambulance and they arrived at the address at 11.39am. Paramedics from EMAS were met at the address with Mr Kannan's daughter and son in law. The paramedics were informed that he had taken approximately [redacted] Metformin and approximately [redacted] Indapamide tablets. Mr Kannan informed the paramedics that he had taken the tablets to end his life and did not want to continue living. Mr Kannan was refusing to go to hospital. The paramedics attending conducted what they described as a 2 stage mental capacity assessment. The crew deemed him to have capacity and therefore could not in their opinion force him to go to hospital with them. The paramedic made contact with Mr Kannan's GP, who spoke with Mr Kannan directly and reiterated the risks of not receiving hospital treatment. The GP believed that a mental capacity assessment had been carried out by the paramedics and therefore advised them to make contact with the crisis team to review the patient urgently. The GP also confirmed he had undertaken a mental capacity act assessment and that Mr Kannan had capacity to make his decision not to go to hospital. It was the GP's understanding that he was told Mr Kannan had taken [redacted] tablets of Metformin not [redacted], this information he became aware of after Mr Kannan's death. The paramedic made contact with the clinical access line (CAL) at NHCT who advised that they would not attend until the next day and that they should ask the GP to make a

	mental health act assessment referral. The paramedic advised them that Mr Kanna would not survive. The paramedic made a further call to the GP who repeated his previous advice that it was a matter for the crisis team. The paramedics tried one more time to persuade Mr Kannan to go to hospital but he refused and asked them to leave. They provided advice to his daughter that if he deteriorated they should call for an ambulance and they left the property as this was Mr Kannan's wish. At 5am on the 19th of March 2025 EMAS received a 999 call from Mr Kannan's son in law reporting that his father in law had taken an overdose of tablets and was suffering with low level breathing. This call achieved a category 3 disposition. At 6.10am on the 19th of March 2025 EOC received a request through the electronic gateway from NHS 111 for Mr Kannan. Information passed to them was that Mr Kannan required an emergency ambulance response for sepsis. At 6.17am a paramedic led double crew was dispatched and at 6.45am the dispatch officer allocated a technician led double crewed ambulance. At 7.11am the dispatch officer allocated a paramedic working on a fast response vehicle. At 7.14 the dispatch officer allocated a paramedic working on a fast response vehicle. The first ambulance response arrived at 6.27am. Mr Kannan was assessed as actively suicidal, he appeared confused and had a limited level of consciousness. It was on this occasion that EMAS confirmed Mr Kannan was assessed as lacking mental capacity, and that this was due to an impairment of brain function. He was unable to understand, retain, or weigh information appropriately, and could not effectively communicate a decision. Due to the difficulty in removing Mr Kannan from the property the hazardous area response team (HART) were called to assist in removing him so that he could be taken to hospital. They left the property at 8.01 and arrived at Kings Mill Hospital at 8.14 and was handed over to hospital staff at 8.35. Mr Kannan suffered a cardiac arrest shortly after and was pronounced deceased at 8.55am on the 19th of March 2025.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed a matter giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTER OF CONCERN** is as follows – • Lack of joint agency working/policy work on the Mental Capacity Act Assessments and Mental Health Act Assessments setting out the roles and remit of service providers. • Lack of training of service providers on the Mental Capacity Act assessments and the process for referrals for Mental Health Act assessments.

	I heard evidence at the inquest from EMAS that it would be for the NHCT crisis team to attend for a MHA assessment if the patient was deemed to have capacity and that EMAS do not make referrals for mental health act assessments. I heard evidence from NHCT that it would be for either the family, GP or the attending medical practitioner , in this case EMAS, to request a MHA assessment. There is a clear lack of understanding between these service providers as to what actions should be taken and by who. In my opinion, action should be taken to prevent future deaths and I believe you have the power to take such action.
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 the 26th of December 2025. 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. Family. 2. All IPs 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	**30th of October 2025 Miss Sarah Wood**