ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

<table>
<tr><td></td><td>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. Ruth Hawkins, Chief Executive , Nottinghamshire Healthcare NHS Foundation Trust
2. [redacted] Medical Director, CRI
3. [redacted] Locality Director for Nottinghamshire Area Team, NHS England.

For the avoidance of doubt, it is expected that NHS England will cascade this report to all commissioners in Nottinghamshire (ie both city and county) who are responsible for mental health and GP provision.</td></tr>
<tr><td>1</td><td>CORONER

I am Heidi Connor, assistant coroner, for the coroner area of Nottinghamshire.</td></tr>
<tr><td>2</td><td>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.</td></tr>
<tr><td>3</td><td>INVESTIGATION and INQUEST

On 12 October 2015 I commenced an investigation into the death of Philip Anthony Denning, aged 25. The investigation concluded at the end of the inquest on 4 February 2016. The conclusion of the inquest was accident. The cause of death was diamorphine intoxication. His date of death was 23 July 2015.</td></tr>
<tr><td>4</td><td>CIRCUMSTANCES OF THE DEATH

This is a summary of the evidence we heard at the inquest. It is not intended as a full history.

Philip had a history of substance misuse since his teenage years. This included using heroin in his later life. He also had a history of depression and had been prescribed anti-depressants by his GP for a number of years. We heard evidence of multiple overdoses in the past.

The evidence showed that, from at least May 2014, Philip's GP felt that he needed help not just with substance misuse, but also mental health issues. Philip himself wanted this help, as did his parents. He was receiving help from CRI, between October 2014 and January 2015, and then again from March 2015 onwards. I heard evidence from the medical lead of New Directions (CRI), himself a consultant addiction psychiatrist. He set out clearly the role and aims of CRI. He told us that, whilst that service employs addiction psychiatrists, they would not be able to provide psychology input or talking therapies to patients.</td></tr>
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It is fair to say that the evidence highlighted an element of frustration for Philip's GPs, in the sense that they clearly believed that Philip needed psychology input, but it was far from clear how best to access this for him. I was told that this is a common frustration in current GP practice, when dealing with patients with both substance misuse and mental health problems.

After attending the ED at QMC on 2 December 2014 following an overdose, he was seen by a consultant psychiatrist, employed by Nottinghamshire Healthcare NHS Foundation Trust. He offered Philip a further appointment (29 January 2015). Philip did not attend that appointment. Philip's family were adamant that he was not given that appointment date, and would have attended if he had been given it, as he was himself trying to access help. Philip was discharged by Nottinghamshire Healthcare on that date, following his non-attendance. The evidence suggested that neither Philip nor his GP was made aware of this discharge. He had in fact taken further overdoses in the days before 29 January 2015. Nottinghamshire Healthcare has already undertaken to remind staff of correct policy when patients do not attend initial follow-up appointments, and regarding notification to patients and their GPs.

Philip was referred to Dual Diagnosis, but after considerable delay, their advice was that he was not suitable for that service, and he should continue to be treated by the CRI.

In April 2015, CRI asked Philip's GP to follow up a psychology referral for him. When the GP contacted CRI by telephone in June 2015 to try to clarify matters, to discuss Philip's need for psychology input, and to explain that Dual Diagnosis were not able to accept him as a patient, she was told by an employee of CRI that they would arrange for an addiction psychiatrist to see Philip. Sadly, Philip died less than a month after that.

The evidence suggested that Philip had a period of abstinence, or at least lower intake, in the months before his death. After receiving a benefits payout, he appears to have bought and used heroin, resulting in his death. I did not record a conclusion of suicide. I would be required, for such a conclusion, to be satisfied beyond reasonable doubt that Philip intended to take his own life.

It is not certain that, if further psychology input had been offered, Philip's death would have been avoided. The difficulty and lack of clarity in managing patients with both substance misuse and mental health issues was clearly seen during this inquest however, and I am concerned that 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.

5 **CORONER'S CONCERNS**

The **MATTERS OF CONCERN** are as follows :

1. Patients with both substance misuse and mental health issues used to be managed under the same 'umbrella' – ie by Nottinghamshire Healthcare. Since October 2014, Nottinghamshire Healthcare has only dealt with a small subsection of these patients (broadly speaking, those with severe and enduring mental illness).
2. Since the introduction of the CRI in October 2014, patients with both categories of problem, have, in the county, been managed by CRI. They are not equipped or commissioned to deal with the additional psychology needs of their patients. We were told that the only way that they can try to arrange this for their patients is via their GPs. It appears that, on the facts of this tragic case,even an employee of CRI itself may have mistaken their remit.
4. The CRI is an entirely separate entity from Nottinghamshire Healthcare and has no access to RiO, Nottingham Healthcare's electronic record-keeping system. If,

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for instance, one of their patients had been seen regularly by Nottinghamshire Healthcare following overdoses, they would not be aware of this unless their patient told them about this.

5. As I understand it, the question of patients giving their consent for access to RiO records by CRI (and indeed for Nottinghamshire Healthcare to have access to CRI records) has not been considered by either organisation. Aside from potential cost and governance issues, none of the senior clinicians involved could tell me any disadvantage to such access being considered. It appears not to have been considered at all to date. There appears to be very little currently by way of joint working or information-sharing between CRI and Nottinghamshire Healthcare.
6. Even aside from the question of shared access to key records held by Nottinghamshire Healthcare and CRI, I am concerned that the current approach of having a separate organisation dealing only with substance misuse carries a risk of future deaths. Commissioners and providers will need to consider these matters carefully.
7. It is also clear that there is a significant lack of understanding in primary care about how to access help for patients like Philip. The respective roles of CRI, Nottinghamshire Healthcare and primary care talking therapies appear to be widely misunderstood. I have included reference to GPs and primary care largely with a view to raising awareness in this area.
8. It is important that the response to this report includes reference to the following matters :
   a. Information sharing – particularly between Nottinghamshire Healthcare and separate providers for substance misuse patients, as matters currently stand.
   b. Whether it remains appropriate for services to be provided in this more fragmented way, with all the risks highlighted by this case.
   c. Awareness of the relevant services available – particularly to those working in primary care.
9. Given the geography of this case, Framework was not involved in this matter. It seems to me to be sensible to include organisations caring for patients in the City and not just the County, so that the issues are dealt with across the jurisdiction. A copy of this report has therefore been sent to them as well.

6 **ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe you and your organisations have the power to take such action.

7 **YOUR RESPONSE**

You are under a duty to respond to this report within 6 months of the date of this report. I, the coroner, may extend the period.

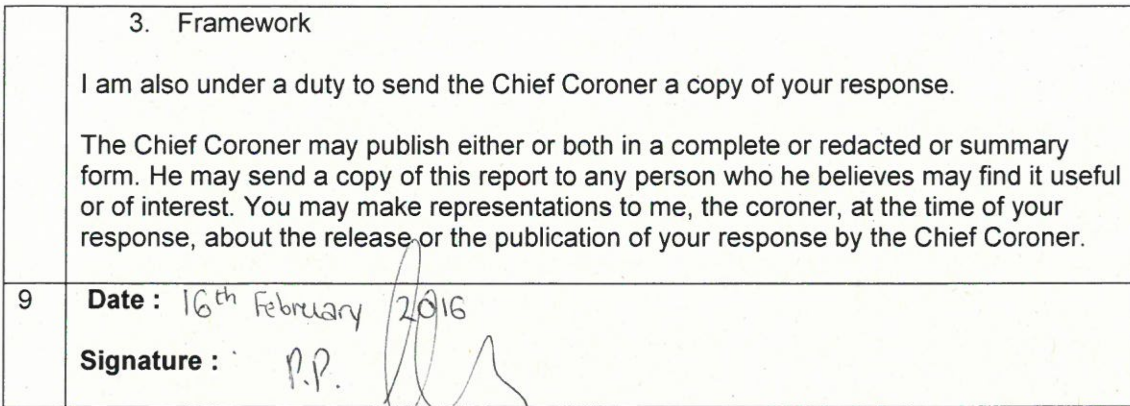
You will appreciate that this is considerably longer than the usual 56 days, and is granted in order to ensure that there is time to consider these matters fully – by both commissioners and providers – and provide a joint response.

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.
2. Philip's GP



	3. Framework I am also 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 coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Date :** 16th February 2016 **Signature :** P.P.