	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **Interim Head of Mental Health Commissioning, Nottingham CCG** 2. [redacted] **Assistant Director of Commissioning- Mental Health, Cancer and Acute contracts, Nottingham CCG** (via [redacted]
1	**CORONER** I am Mrs Heidi Connor, 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 6 February 2017 I commenced an investigation into the death of Kate Dolby, aged 36. The investigation concluded at the end of the inquest on 28 March 2017. The conclusion of the inquest was suicide. Kate took an overdose of Propranolol after carrying out research into this. Please note that the issuing of this report has been deliberately delayed, for the reasons set out below.
4	**CIRCUMSTANCES OF THE DEATH** The family advised us that Ms Dolby preferred to be referred to as Kate, so I will respect that wish in this report. Kate was born on 29.8.80. Her past psychiatric history included an eating disorder when she was a teenager. She had also been prescribed anti-depressants when she was a student. She appears to have suffered an acute psychotic episode in April 2016, resulting in her detention (under s2 of the Mental Health Act) on 10 April 2016. She remained an inpatient at Millbrook until 13 May 2016. During this admission, on 19.4.16, a call was made to the Early Intervention in Psychosis (EIP) team, as it had been decided that Kate should be referred to them. There was confusion about this call. We heard that there are 2 EIP teams – 1 for city and 1 for county. The call was made to the county team. Kate's GP surgery is based in the city. The call, it was also suggested, did not provide enough information for the referral to proceed. Common sense suggests that more information should have been requested, and the referral passed to the correct team. Instead, only a week later, the referral was simply closed. Kate was not even on the waiting list between 26 April and 3 June 2016. This is a clear breakdown in communication which caused delay to a patient awaiting treatment. The only post-discharge review that Kate had after leaving Millbrook on 13 May was a standard 7 day review by the Crisis Resolution Home Treatment (CRHT) team, who felt her well enough to be discharged from their team, to await review by the EIP team. This we know did not in fact happen for a further 4 months.

It was only after Kate's discharge from Millbrook that she was re-referred to the EIP team, on 3 June. She effectively went to the back of the queue again, and we have heard that there was a significant waiting list at that time.

During this time, her GPs were becoming increasingly concerned for Kate. A letter from the GP to her psychiatrist dated 14 June (and chasing letter 9 August) was only replied to by [redacted] on 23 August – and received by the GP practice on 31 August 2016. In her letter, [redacted] says she was worried that Kate may be in the early stages of psychotic relapse, and copied the letter to the EIP team. The EIP team say they never received letters – from the GP or from [redacted] This is a further, worrying breakdown in communication.

Kate was clearly struggling in the months before she was seen by the EIP team. Her GPs were adjusting her medication as best they could, whilst awaiting input from mental health services. During this time, she was prescribed a month's worth of 40 mg Propranolol (84 tablets), for treatment of anxiety symptoms. Kate's family and housemate became increasingly concerned about her. She attended the Emergency Department on 27 July saying she felt suicidal.

She was triaged by an EIP nurse on 13 July – we heard that this was part of the process started by the trust to deal with long waiting lists. The nurse who saw her stated she thought Kate was at risk of relapse without further support. It was only after a phone call from Kate's GP directly to the EIP team on 19 September 2016 however, a full 2 months after that, and 5 months after she was first referred to this service, that things started to happen.

Kate met her care coordinator, [redacted] on 22 September. [redacted] asked [redacted] (consultant psychiatrist with the EIP team) to see her urgently. She said she was aware how long Kate had been waiting, and that she was concerned about her low mood. [redacted] fitted Kate in before her usual clinic appointments, on 27 September 2016. Although Kate talked to both clinicians about thoughts of suicide, she said she had no plans to carry this out. She was seen and contacted regularly by [redacted] after 27 September, and seemed to be doing well. Her housemate described "seeing some of the old Kate coming back". Her father told us that she seemed the happiest they had seen her for a long time, just a couple of days before her death.

Sadly, we know that Kate was found dead at her home address on 9 October 2016. Her cause of death was Propranolol toxicity. The police witness told the court Kate had previously carried out research on her phone about how to overdose using Propranolol. She had no previous history of accidental mixing up of tablets or dosages.

A key question was whether earlier referral to the EIP team would have made a difference for Kate. [redacted] candidly accepted that it may have done. It is of course difficult to know with any degree of certainty. I cannot say, to the required standard of the balance of probabilities, that earlier treatment would have avoided her death.

The trust has not sought to deny or dress up the undoubted failings in this case, which has been helpful to this investigation. There was delay and breakdown in communication at multiple stages, resulting in significant delay in Kate receiving the help she needed. It was more than 5 months between the first referral, which I find was on 19 April, and her first meeting a care coordinator and subsequently a psychiatrist in this team. Kate's family quite rightly refer to a delay in support for her. That is the key issue in this case, and I have heard evidence from the trust about changes that have been made to reduce

	the risk of this happening again. We have heard that, because of national guidance issued in April last year, patients referred to the EIP service are now referred to a Single Point of Access, and allocated a care coordinator within 2 weeks. Early figures suggest the trust is doing very well with achieving this in the vast majority of cases.
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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you. **The key area of concern is :** As with so many matters like this, a central issue is funding. The NHS, and I think it is fair to say, mental health services in particular, are having to spread resources ever more thinly. The trust has previously raised this issue and appointed 3 more nurses to deal with demand. They have approached the organisation that funds them, Nottingham City CCG, for funding for 6 more nurses. At present, it is somewhat reassuring that most patients are being reviewed by care coordinators from an early stage, but it would appear there is an ongoing problem with having enough doctors to see these patients. The system appears to rely currently on care coordinators identifying those in urgent need and trying to arrange appointments for them, sometimes outside of usual clinical hours. This seems a somewhat precarious system, which relies to some extent on the goodwill of the clinicians themselves. The evidence I heard was that an independently commissioned report concluded that the service requires another full-time consultant in the EIP team. I am aware that recruitment in mental health services is often difficult and time-consuming, and therefore consider that the process for this should be considered without delay. I was told that the CCG was to make a decision about a request for further funding shortly after the conclusion of the inquest. The trust requested funding for 6 more nurses and 1 full-time consultant. It is clear that there is an ongoing need for more staff to deal with patients requiring the services of the EIP team. I asked the trust to advise me on the outcome of their funding request, and was subsequently advised (by email from their legal advisor on 24.4.17) that, at present, funding has been agreed for 3 care-coordinators, an administrator, and 0.4 medic to support EIP access. On the basis of this information, I remain concerned, particularly about funding for further medics, in this team, and have elected to formalise these concerns in a Regulation 28 Report. There were undoubtedly failings and communication breakdowns contributing to the delay in Kate's case. However I find that the most significant factor in the delay was the workload and waiting list. This was the key cause, certainly from 3 June 2016 onwards, which is very much the bigger part of the delay in this case. The trust has addressed most of these issues and I therefore see no benefit in addressing this report to Nottinghamshire Healthcare NHS Foundation Trust as well. The key area of outstanding

	concern relates to funding.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you / 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 14 July 2017. 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. Kate's family. 2. Nottinghamshire Healthcare NHS Foundation Trust 3. [redacted] 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	**19.5.17** ***H.J.Connor***