JAMES REUBEN MAXWELL ADAMS

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Secretary of State for Health – Mr Jeremy Hunt** **The Chief Executive of NHS Curnow Commissioning Group** **The Chief Executive of NHS England**
1	**CORONER** I am Dr Elizabeth Emma Carlyon, the Senior Coroner for the coroner area of Cornwall
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	**INQUEST into the death of James Reuben Maxwell Adams between 27th – 29th July 2015**
4	**CIRCUMSTANCES OF THE DEATH** James Adams was found dead between 17.30 – 17.40 at his home address, [redacted] on 10th August 2012 . He was found fully clothed on the sofa with a clear plastic bag over his head with two plastic tubes leading from the bag to two helium cylinders which were adapted to provide a continuous stream of helium. His mobile phone was on his lap and he had head phones attached to the phone in his ears. An almost empty bottle of vodka was on the floor next to his feet. Suicide notes were found nearby his body. The downstairs doors to the property were secure and the police entered through an upstairs window. A handwritten note was seen in the window of his front door between 10.00 - 10.30am that morning saying "Call Police". The police were informed at 10.55am and did not action the request until a further phone call at around 5.00pm that day. He was last heard alive the evening before but his door was seen open at around 1.30am that morning. He suffered from persistent depressive disorder, alcohol dependency; and a mixed type personality disorder and was chronically depressed. He was known to have purchased a helium suicide kit to take his own life and was being treated by the mental health services. The post mortem toxicological result found ethanol level of 243 mg/100ml which may have had a detrimental effect on motor and cognitive function. It was not clear the intention of the note at the door window nor was it possible to establish the time of death. Mr Adams was chronically suicidal and the mental health services were aware of his suicide kit and it was deemed most appropriate to treat Mr Adams in the community at that time due to the fact that he had built up relationships with his psychiatrist and treating mental health professionals. There were issues over the police reaction time when there were concerns for welfare of a patient with mental health issues in the community and the avenues open to them and information sharing

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 **MATTERS OF CONCERN** are as follows. – The inquest heard how lessons had been learnt from the inquest and that the working relationship with the Devon and Cornwall Police and the local Mental Health Services (provided by Cornwall Partnership NHS Foundation Trust) had been improved and formalised through appropriate protocols and Memorandum of Understanding. One continuing difficulty was the "lack of acute psychiatric beds" in Cornwall. In addition, the police had found that on a regular basis, the designated mental health places of safety were not staffed to the appropriate level and the patient could not be left there. The result of this was that patients were being inappropriately detained in police cells by way of a safety net or were regularly being transported out of County as far as Manchester and Bournemouth to access the appropriate acute mental health bed. Cornwall Partnership NH Foundation Trust representative advised the Coroner that Cornwall has pro-rata less acute mental health beds than the national average. The preferred option for the mental health professionals was to treat local patients locally where they are known or are able to build up relationships with the local mental health team which is something that cannot happen if the patient is transported out of County. Further, the treating Psychiatrist is required to travel to the out of county unit to review the patient which results in valuable Consultant time not being available to local patients which may need access to them at a critical time. The result of this is that unnecessary stress is put on patients which can result in a deterioration of the patients mental health (and possibility death) at a time when the patient needs increased support and treatment.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. A review of the provision of acute psychiatric beds in Cornwall to avoid the transfer of patients out of county or the use of police custody centres as a safety net.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by1st October 2015. 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, [redacted]. I have also sent it to The Chief Constable of the Devon and Cornwall Police and The Chief Executive of Cornwall NHS Foundation Trust who may find it useful or of interest. 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	**7th AUGUST 2015**	**Dr E E Carlyon – Senior Coroner for Cornwall** Elizabeth Emma Carlyon