DAVID W. G. RIDLEY
Senior Coroner for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Jackie Doyle-Price MP** **Parliamentary Under Secretary of State for Mental Health, Inequalities and Suicide Prevention** **Department of Health and Social Care** **39 Victoria Street** **Westminster** **London** **SW1H 0EU**
1	**CORONER** I am DAVID W. G. RIDLEY, Senior Coroner for Wiltshire and Swindon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 26/06/2018 I commenced an investigation into the death of **Heather Birchall**, and an inquest into her death was opened by Assistant Coroner Nicholas Rheinberg on 22 August 2018. On 21 June 2019 I concluded Heather's inquest. I found that the medical cause of death was 1a) Alcohol, Citalopram, Codeine, Paracetamol and Propranolol Toxicity 2) Bronchopneumonia, alcohol dependence and depression In box 3 of the Record of Inquest I recorded how, when and where Heather came by her death as follows:- "Heather was confirmed dead at 1838 on Sunday 22 June 2019 by an attending paramedic at a location on waste ground to the south of The Recycling Centre, Churchfields Industrial Estate, Salisbury, Wiltshire. Earlier that afternoon against a background of excess alcohol consumption Heather consumed excess amounts of Paracetamol (88mg/l blood), Codeine (1.6mg/l blood), Propranolol (4.2mg/l blood). The combination of the above more likely than not led to respiratory depression and death. Heather also had a developing bronchopneumonia which more likely than not contributed to the mechanism of her death. Heather was dependant on alcohol and also more likely than not was suffering from depression both of which contributed to her actions." Having considered the evidence I felt that there was insufficient evidence to make a finding of fact, on a balance of probabilities that Heather had intended to take her own life at the time, she took the medication in conjunction with previous alcohol consumption and I therefore recorded as a conclusion one of **Drugs/Alcohol related**.

4	**CIRCUMSTANCES OF THE DEATH** Heather was a homeless lady having lost both her parents during her teens. A forensic psychiatrist was of the view that she did have mental health problems although sadly for Heather, whilst having mental capacity she appeared to be reluctant to engage with mental health professionals. As part of the investigation and although Heather actually died on the 22 June 2018, she had come into contact with the Police on 17 and 18 June 2018 the latter of which she had been arrested and taken to Melksham Police Station. Whilst at the police station she was subject to an alcohol withdrawal assessment which did include a mental health assessment undertaken by a paramedic. A decision was taken later the same evening to release Heather back into the community. There was no finding of any failure on part of either the Police or the healthcare professionals insofar as the care afforded to Heather whilst a Melksham Police Station. The investigation did however as part of the wider investigation give rise to some matters which are of concern to me which I have addressed in the next section,
5	**CORONER'S CONCERNS** At the final hearing I heard evidence from [redacted] who was the paramedic involved in the assessment of Heather on 18 June 2018. He had primarily been called to give evidence so that I could understand a little more in terms of the process by which a detained person is medically assessed whilst in police detention and also there was an issue in relation to the recording of his findings which needed to be raised with [redacted] What arose during the questioning was a problem which may affect other healthcare professionals in a similar situation and in respect of which may cause a problem that may lead to a future death if not addressed. Wiltshire Police contract with G4S Health Services (UK) Ltd in relation to the provision of healthcare services at their custody suites in Wiltshire and Swindon. Principally due to the ever-increasing challenges that people with mental health issues present to front line emergency services, Wiltshire Police operate an arrangement called "Street Triage" whereby 24 hours a day there is a mental health professional available at the Force Control Room with full access to mental health records. Working alongside the G4S healthcare professionals, at least between the hours of 0800hrs-2000hrs, are personnel from the Liaison and Diversion Service (LADS). Coincidentally the same healthcare trust is responsible for the provision of both those services. As you will appreciate when somebody is in state detention, the state is under an obligation having regard to Article 2 of the European Convention of Human Rights to safeguard life in those circumstances. One of the concerns that arose relates to G4S healthcare professionals and any other healthcare professional in this situation when asked to carry out a front line assessment which could include mental health features, that those individuals may not have the fullest amount of information that is available so that they can make an informed decision as to whether or not for example further healthcare input is required, such as for example a formal mental health at assessment. Whilst a problem insofar as getting a complete picture did not seem to be quite such an issue when personnel from LADS were available it would appear that out of those hours, if a G4S healthcare professional wanted to make enquiries insofar as an individual's mental health background which potentially might be within the knowledge of the relevant healthcare trust, that when an approach is made to the Street Triage team out of hours that more often than not the issue of confidentiality was raised to withhold information or I felt that equally there was a danger that selective information might only be passed at best to the G4S healthcare operative. The concern that I was left with was that the healthcare professionals from G4S and arguably at the end of the day Wiltshire Police whose ultimate responsibility it is to safeguard life when an individual is in Police custody are effectively trying to do a job, through their contract service providers (G4S), in circumstances whereby in trying to discharge their duty having regard to Article 2 of European Convention of Human Rights they were doing so effectively, as a consequence of patient confidentiality, with one arm tied behind their back. The reason I am writing to you is that I am aware that currently mental health legislation generally is under review and to the extent that this issue insofar as confidentiality as between healthcare professionals from different organisations including healthcare providing companies has not already been raised, then I would like to air the concern via this report. It is my view in relation to other hearings that confidentiality can equally pose a problem insofar as

	communications between healthcare practitioners on the mental health side and a patient's family. Either of which may have relevant information that would have been of benefit to the other and in respect of which could prevent the loss of life through self-harm and suicide. Whilst the issue of confidentiality should be respected I am concerned that consideration needs to be given to realistic and practical exceptions to that general principle especially if the aim is with a view to safeguarding life. At the end of the day such a matter in terms of reforming mental health legislation is a matter for Parliament but I would like to raise this concern with you following the evidence I heard as part of Heather's inquest final hearing.
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 23 August 2019. 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] [redacted]Force Solicitor, Wiltshire Police, Wiltshire Police Headquarters, London Road, Devizes, Wiltshire SN10 2DN [redacted]Litigation Lawyer, G4S Legal Department, Regional Management, UK & Ireland, Southside, 105 Victoria Street, London SW1E 6QT I have also sent a copy of this report t[redacted]Chair, Avon and Wiltshire Mental Health Partnership NHS Trust, Bath NHS House, Newbridge Hill, Bath BA1 3QE who may find its contents 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	Dated 28 June 2019 Signature Senior Coroner for Wiltshire and Swindon