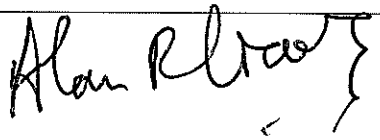
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Secretary of State for Health** **2. NHS England**
1	**CORONER** I am Alan Romilly Craze, Senior Coroner for the area of East Sussex
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 29th June 2018 I commenced an investigation into the death of Reece Tristan Lapina-Amarelle, aged 20 years. The investigation concluded at the end of the inquest on 25th April 2019. I am attaching a copy of the Record of Inquest. The conclusion of the inquest was suicide and the medical cause of death was multiple injuries.
4	**CIRCUMSTANCES OF THE DEATH** Two documents were presented to me which are a powerful statement of the peculiar problems the authorities faced in Mr Lapina-Amarelle's situation. I can do no better than to attach copies of those documents. They are the statement of Doctor [redacted], the psychiatrist responsible for him when he was admitted (on very many occasions), coupled with the Level 2 Comprehensive Serious Incident Review Report. A study of those two documents will give the history and it can be seen that all available in-patient and community programmes had been unsuccessful, and the Sussex Partnership Foundation Trust (the Mental Health Services) simply had no other option but to detain him in hospital or to discharge him. He had been providing drugs to other in-patients in hospital and so understandably they did not want him to continue there. They therefore discharged him with the full knowledge that he would immediately proceed to try to take his life, which is exactly what he did. The only preventative measure that the Trust could take was to telephone the Beachy Head Chaplains and the Police to warn them that Reece was on his way to Beachy Head.
5	**CORONER'S CONCERNS** In my opinion there is a risk that future similar deaths will occur unless action is taken. The **MATTERS OF CONCERN** are as follows. – (1) There are no resources and no system of treatment for people who present with serious mental illness and alcohol or drug misuse histories.

	(2) There is insufficient sharing of information between the Mental Health Trust and CGL (the Substance and Alcohol Misuse Service). (3) That latter service is voluntary and, outside the criminal justice system, the subject cannot be forced to access and receive help or to cooperate with that service. (4) In my opinion the Mental Health Act is out of date in that it does not recognise or accept responsibility for providing a plan of action to deal with people such as Reece. (5) Twenty years ago the connection between the use of strong drugs in teenage years and subsequent mental health (often very serious) was not fully recognised. However nowadays there is far greater use of drugs which are growing ever stronger, and a very considerable number of people with mental health issues in prison or in the community have developed or worsened their conditions by the use of cannabis and other illegal substances. The Mental Health Act still concentrates on therapy without giving sufficient emphasis, in my view, to safety and, in blunt terms, keeping people alive. In my view without action these issues are simply going to get worse.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 4th October 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, namely the family of the deceased and Sussex Partnership Foundation NHS Trust. I am also under a duty to send the Chief Coroner a copy of your response and I shall share it with the two Interested Persons. . 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	 **Alan Romilly Craze** **Senior Coroner for East Sussex** **09/08/2019**