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. Matthew Trainer, Chief Executive Oxleas NHS Foundation Trust** **2. [redacted] ADAPT, Bexley Locality Community Mental Health Team, Erith Centre**
1	**CORONER** I am Jacqueline Devonish, assistant coroner, for the coroner area of South London
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 17 October 2019 I commenced an investigation into the death of Billy James Jenkins, 31. The investigation concluded at the end of the inquest on 20 February 2020. The medical cause of death was asphyxia due to being suspended by the neck, with underlying alcohol and cocaine intoxication. The conclusion of the inquest was that Billy Jenkins took his own life by hanging following an assessment after which he felt helpless because there had been no clear mental state examination and a potential missed opportunity to consider an appropriate referral.
4	**CIRCUMSTANCES OF THE DEATH** On 12 August 2019 Billy Jenkins was found hanging by the neck in a hotel room bathroom. He had checked in in the early hours of the morning after visiting his mother and presenting as unusually calm. Billy Jenkins had a long history of alcohol and cocaine abuse when he was feeling in low mood. An empty bottle of vodka was found in the room. There were a number of social factors contributing to his low mood at the time of the incident. He had reported ongoing suicidal ideation, and reported three previous suicide attempts but no active plan. He had been prescribed anti-depressants by his GP. He generally presented as agitated and impulsive but had always sought support from clinical services but had been resistant to alcohol and drug support believing that he had an undiagnosed bipolar disorder. He was assessed by ADAPT on 3 July 2019 but left the assessment feeling hopeless. His mother was present throughout his assessments and felt that he had not been listened to, that he had not been diagnosed and that insufficient information had been gathered at assessments to be able to properly support him.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. –

	(1) The findings of the internal investigation by Oxleas NHS were that the assessment undertaken by the Community Mental Health Nurse did not illicit sufficient information to enable the multidisciplinary team to properly review Mr Jenkins' mental health. Despite this the multi-disciplinary team proceeded with a review and decided that he did not have a mental health condition, without seeking a further assessment (2) The Community Mental Health Nurse did not document her formulation or impression. The plan moving forward was not robust and did not explore protective factors or minimisation of harm and there was an over-reliance on alcohol and drug use as the cause of his suicidal ideation. There appeared to be no proforma of questions to ask. (3) As a direct consequence of the limited information gathering Billy Jenkins was not properly assessed and it was not known whether he had a mental health diagnosis which required treatment. (4) It was not known whether as a result of this death there had been any lessons learned by the teams involved in care and treatment of Billy Jenkins, or whether there had been any training or support requirements identified for the Community Mental Health Nurse.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 17 April 2020. 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 Person: [redacted] I have also sent it to [redacted] Trust Investigator 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	**21 February 2020** Jacqueline Devonish