REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Chief Officer NHS Norfolk and Waveney CCG, Lakeside 400, Old Chapel Way, Broadland Business Park, Thorpe St Andrew, Norwich, NR7 0WG**
1	**CORONER** I am Sean Horstead, assistant coroner, for the coroner area of Cambridgeshire & Peterborough
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 28th February 2020 I commenced an investigation into the death of **Sean Kay**, 50 years of age. The investigation concluded at the end of the inquest on 3rd November 2020. The conclusion of the inquest was one of suicide. The medical cause of death was I(a) drowning; II Zopiclone and morphine intake.
4	**CIRCUMSTANCES OF THE DEATH** Sean Kay had been suffering from mental health problems, including anxiety disorder, insomnia and (latterly) depression for some years. He received medication for his anxiety and low mood from his GP but to limited beneficial effect. In December 2019 he was referred by his GP to the mental health services of the Norfolk & Suffolk NHS Foundation Trust. Mr Kay was referred to the Early Intervention in Psychosis Team (EIPT) who, after assessment, determined he did not meet the criteria for first episode of psychosis. As a consequence, EIPT planned to encourage him to continue to work with the (primary care) Wellbeing Services (WBS) with whom he had contact from January 2020. However, because of the added complexity that Sean had been identified by the EIPT as being in the *'at risk mental state'* (ARMS) cohort of patients, he was deemed to be too complex for the WBS, by the WBS. An 'Interface Team Meeting' involving (amongst others) the WBS and the EIPT, scheduled for the 20th February 2020, to discuss the future care provision for Mr Kay, did not take place due to an administrative error and Mr Kay was not discussed at the meeting as planned. Consequently, at the time of his death six days later, Mr Kay was awaiting confirmation of whether – and/or from whom - he would be receiving support for his on-going mental health concerns. On 26th February 2020 Mr Kay's body was recovered from an area of water near Stonea Bridge on Sixteen Foot Bank, Stonea. Life was confirmed extinct at the scene. Mr Kay had taken his own life whilst the balance of his mind was disturbed.
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 evidence clearly identified a gap in service provision in the Norfolk and Waveney area for the cohort of patients into which Sean fitted. Although having been identified as ARMS by the EIPT in Norfolk and Waveney, Sean nonetheless did not fit the strict criteria for accessing that service as he was deemed to have not yet suffered a first episode of psychosis; however his level of risk was sufficiently high that he was also considered unsuitable for WBS. Additionally, the evidence confirmed that Sean did not fit the criteria of either the Community Mental Health Team, the Crisis Team or MIND. In contrast, in the neighbouring Suffolk area (and the evidence suggested in many other areas of the country) ARMS patients *are* recognised as falling under the commissioned EIPT umbrella and therefore receive commissioned assessment, treatment and management from that team. This lacunae in service provision in Norfolk and Waveney meant that, at the time of his death, Sean fell between services and did not receive any appropriate care. In my opinion the continuation of such a lacunae in commissioned service provision gives rise to the risk of future deaths.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 23rd June 2021. 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: the family of the deceased; Norfolk and Suffolk NHS Foundation Trust. 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	**Sean Horstead** **HM Assistant Coroner for Cambridgeshire & Peterborough** **28th April 2021**