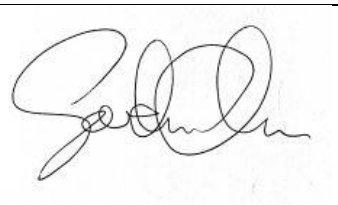
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Nottinghamshire Healthcare NHS Foundation Trust** **2. All other interested persons, namely:-** **a. The family;** **b. Nottinghamshire Police;** **c. Dr [redacted], psychologist;** **d. Dr [redacted], GP; and** **e. Aviva Insurance.**
1	**CORONER** I am Mr Gordon Clow, Assistant Coroner for the coroner area of Nottinghamshire.
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 30 November 2020 I commenced an investigation into the death of Paul Ashley Barton who was born on 10 September 1960 and who died, aged 60, on 28 November 2020. The investigation concluded at the end of the inquest on15 September 2021. The conclusion of the inquest was a narrative conclusion: "*Mr Barton took his own life. I consider it likely that on 28 November 2020 the balance of Mr Barton's mind was disturbed to such an extent that he was not capable of making a decision to end his life that day. Mr Barton would have been likely to have had a highly distorted perception of the nature of his relationship difficulties and will have weighed in the balance factors which were not rationally relevant to such a decision when proceeding, on impulse, to take the actions which ended his life.* *There were missed opportunities to intervene by means of crisis support from secondary mental health services prior to Mr Barton's death. I am unable to conclude that had this been in place prior to his death Mr Barton would have survived, given the complexity of his presentation and the limited opportunity, in terms of time, to successfully intervene. Although there is evidence that Mr Barton was troubled by the lack of assessment and diagnosis, there is insufficient evidence, given the other more compelling social stressors present in Mr Barton's circumstances, to conclude that this concern more than minimally contributed to Mr Barton's actions that day. It is more likely that his thoughts were dominated by his distorted perceptions of his family circumstances*."
4	**CIRCUMSTANCES OF THE DEATH** Mr Paul Barton suffered from significant symptoms of distress, personality changes, dysfunctional behaviour and possible paranoid or delusional thoughts. The precise nature of Mr Barton's mental health, personality and / or neurological difficulties were not assessed prior to his death. Mr Barton experienced regular thoughts of ending his life and he engaged in acts consistent with such intentions on numerous occasions including 22 October, on or around 5 November, 11 November, 12 November and 14 November 2020. Against

	this background, Mr Barton took his own life by means of hanging on 28 November 2020. There was no third party involvement and no evidence of any suspicion.
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 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 approach of the Crisis Resolution Home Treatment Team of considering their role to be limited to avoiding the need for patients to receive inpatient treatment. The primary role of any medical professional ought to be the protection of life, but within the written and oral evidence from the CRHTT the focus was on prevention of hospital admission alone. (2) This inquest was one of a number of inquests I have conducted where staff members from Nottinghamshire Healthcare NHS Foundation Trust have placed great reliance upon their interpretation of a patient's intention and / or a patient's denial of ongoing suicidal intention. This is so even where, as was the case for Mr Barton, there is a clear and established pattern of fluctuating and contradictory intentions and desires towards suicide. (3) The quality of the Trust's own investigation into the circumstances of Mr Barton's death. It failed to identify themes of concern. It included many false and inaccurate statements, failed to challenge false assumptions made at the time and introduced new false information which was not taken from any available records. It caused distress to the family and did not reassure me that the Trust had taken an appropriate response to the concerning facts of this case.
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 13 December 2021. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting 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 Interested Persons set out above. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	 **Mr Gordon Clow, HMAC** **14 October 2021**