	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Dr Ify Okocha, Medical Director and Deputy Chief Executive, Oxleas NHS Foundation Trust, Pinewood House, Pinewood Place, Dartford, Kent DA2 7WG
1	**CORONER** I am Andrew Harris, Senior Coroner, London Inner South jurisdiction
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INQUEST** On 15th May 2019, I opened an inquest into the death of Gary Etherington, who died on 30th November 2018 in his van in a car park in the borough of Greenwich (03191-18 MM). The inquest was concluded on 24th June 2020. The medical cause of death was: 1a Cardiac Arrythmia 1b Amitriptyline and Nortriptyline overdose. II Coronary Artery Disease. The conclusion as to the death was Suicide.
4	**CIRCUMSTANCES OF THE DEATH** Mr Etherington was recorded in February 2019 as having antisocial personality traits and a long history of cocaine use. He was arrested in April 2018 for threats to his ex-wife, had a Mental Health Act Assessment which did not secure her history about extreme mood changes, paranoid behaviour, auditory hallucinations and delusions, which were probably psychotic. His behaviour was then ascribed to substance misuse; it is also recorded that he denied using cocaine for 6 months. In July he was assessed by a Mental Health Trust who elicited a history of auditory hallucinations of two voices to end his life, thoughts about wanting to kill himself all of the time and an admission that his wife says that he sees people who are not there and talks to them. Protective factors from suicide were noted and he was discharged to his GP. He was provided with temporary accommodation and his wife and friend provided other accommodation and he then also slept in his van. He did not qualify for priority housing by the local authority. He went missing on 20th November. He had stolen his wife's Amitriptyline and taken an overdose, and was found dead in his van.
5	**MATTERS OF CONCERN** The coroner found that there were two failures in medical care, namely 1. The failure to contact [redacted] at the Mental Health Act assessment in April 2. The failure to take and consider the history of [redacted] before discharge and to discharge to GP care, without proper consideration of the voices telling him to commit suicide, delusions of people being present, their cause and relation to drug misuse, or the risks to [redacted], about which there was an inadequate plan communicated to the GP. These would have amounted to neglect, had it not been for the fact that there was no causative link with the death. **CORONER'S MATTERS OF CONCERN** are as follows. –

	1. The fact that the deceased was under a restriction order not to contact his ex-wife was cited as a reason that no contact was made by the professionals conducting the MHA assessment. This may raise some process issues but would not seem to be an obstacle to securing corroborative evidence and insight into possible psychosis, especially noting the deceased gave no indication that he opposed such a communication. 2. The witness evidence heard and records consulted give the impression that those professionals involved in his care had discounted his symptoms as non-psychotic, without adequate investigation, underestimated his suicidality and not addressed the concerns of the GP who referred him about his management, and to whom his care passed without any psychiatric follow up or support. 3. Neither failure was recognised or investigated by the Root Cause Analysis which was described as Level 2 Comprehensive and concluded that there were no problems in health care. The court regarded the RCA investigation as unreliable. That causes some concern as to whether the Trust is able to identify care problems in future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths. I believe that the NHS Trust medical director would wish to learn of the evidence given in the inquest about the circumstances of this death (My full judgement is copied to [redacted]) and are in a position to mitigate or prevent future deaths and consider: a) Whether any further investigation of these failures is required b) Whether there is a need to review the conduct of RCA investigations.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Friday 21st August 2020. I, the coroner, may extend the period. If you require any further information or assistance about the case, please contact the case officer, [redacted] Tel: [redacted] and [redacted]
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following Interested Persons: [redacted], the Metropolitan Police Service and London Borough of Greenwich. I am also copying it to the Royal College of Psychiatrists and to NHS England, for information as they may have an interest in the matter. I am also under a duty to send the Chief Coroner a copy of your response. He 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	**[DATE]** **[SIGNED BY CORONER]** **26th June 2020** **Andrew Harris, Senior Coroner**