	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] Chief Operating Officer South Lincolnshire Clinical Commissioning Group Bridge House The Point Lions Way Sleaford Lincolnshire NG34 8GG 2. [redacted] Substance Misuse Lead Public Health Division Adult Care and Community Well Being Lincolnshire County Council Room 3A Orchard House Orchard Street Lincoln LN1 1BA 3. [redacted] Acting Chief Executive We are With You (Formerly Addaction) The New Avenue 26-30 Newland Lincoln LN1 1XG 4. [redacted] Chief Executive Lincolnshire Partnership NHS Foundation Trust St. George's Lincoln LN1 1FS
1.	**CORONER** I am Timothy BRENNAND HM Senior Coroner for the coroner area of Lincolnshire, 4 Lindum Road, Lincoln, Lincolnshire, LN2 1NN.
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3.	**INVESTIGATION and INQUEST** On the 21st May 2018, my predecessor Stuart Fisher commenced an investigation into the death of Toby Peter Edward Nieland, aged 29. The investigation concluded at the end of the inquest on the 13th September 2019. The medical cause of death was: 1a. Hanging 1b. 1c. 2. The narrative conclusion was: Toby Peter Edward Nieland died as a consequence of self-suspension by means of improvised ligature in circumstances where the issue of his intention remains unclear by reason of his Dual Diagnosis condition including mental dysfunction and disordered thinking exacerbated by on-going pain management by reason of alcohol induced Chronic Pancreatitis on a background of anxiety and low mood as to his personal circumstances. In March 2020 I received submissions from the Lincolnshire Partnership NHS Foundation Trust. In August 2020 I received submissions from the Lincolnshire Clinical Commissioning Group.
4.	**CIRCUMSTANCES OF THE DEATH** The deceased had a history that included a Dual Diagnosis with polysubstance misuse and Borderline Personality Disorder. Additionally, he had suffered episodic Anxiety and depressive Disorders and presumed Emotional Unstable Personality Disorder. In 2016 the deceased developed alcohol related Pancreatitis that had deteriorated into a chronic condition causing him to endure persistent significant pain. He was prescribed opiate based analgesia to which he had become addicted. There was a significant history of self-harm and previous attempts to take his life. In March 2018 the deceased had taken an intentional overdose and had received in-patient care but had subsequently self-discharged. In April 2018 he presented to the hospital in Grantham due to an exacerbation of his Pancreatitis and it was noted that that there was a further deterioration in his mental state with associated stressors including

	social problems, hopelessness and suicidal ideation with intent. He was admitted as a voluntary inpatient at Cygnet Hospital Wyke, Bradford where his condition was actively treated, managed and monitored. By the 17th April 2018 the deceased had been assessed and approved for discharge despite warnings communicated by the family that the deceased presented as significant and continuing risk to himself – such warnings not having been communicated to the discharging clinician. He was assessed as presenting as low risk of self-harm and was placed into the care of the Grantham Crisis Resolution Home Treatment Team. The deceased went to reside at temporary accommodation at [redacted] Five Bells Public House, 79 Brook Street, Grantham, Lincolnshire. The facility was accepted to be sub-optimal. On the 2nd May 2018 the Crisis Team considered that the deceased had disengaged from the service and so he was discharged into the Community Mental Health Team. On the 17th May 2018, the deceased was discovered in a collapsed and unresponsive condition having self-suspended himself by a belt to an improvised point of suspension in his room at the Public House. Post mortem samples established an absence of alcohol, but confirmed the presence of a variety of the deceased's prescribed and non-prescribed medications but at therapeutic levels. Between the 17th April 2018 and 17th May 2018 the treatment and care within the community was managed conservatively and in a sub-optimal manner thereby resulting in accepted missed opportunities to monitor and appreciate any deterioration in the deceased that might require an escalation in potential treatment and care. Whilst it was possible that had there been some face to face meeting between the Crisis Team or the Community Mental Health Team this might have had a bearing upon the ultimate outcome, this factor and the consequences of missed opportunities to manage, supervise, treat or care could not be evaluated, even on a balance of probabilities.
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. – 1. The concerns of the immediate family were not communicated to any of the agencies charged with the responsibility of caring for the deceased,

	nor were their views sought (directly or indirectly) as to the suitability of the deceased's accommodation and/or circumstances and/or pathway of treatment and care; 2. Unequivocal evidence established that the deceased suffered from an advanced progressive addiction overlaid with a vulnerable personality amounting to a complex Dual Diagnosis – the significance of which was not appreciated and therefore not managed adequately or appropriately; 3. In any event, even on the basis upon which community care was deemed appropriate, there was an absence of any co-ordination between mental health service provision and addiction services; 4. There was an absence of any adequate "Care Programme Approach" (a package of care used to plan mental health care) resulting in no care coordinator being appointed to monitor the deceased within the auspices of an appropriate care plan; 5. Inadequate evaluation of the deceased's previous history; his purported non-concordance (repeated assertions of not wanting treatment/support that ought to have been interpreted as an increase in his risk); progression of his complex vulnerabilities; his personal circumstances (reaction to accommodation and relationships); events suggestive of on-going misuse of drugs - all gave rise to a missed opportunities to appreciate a series of ascertainable relapse signatures; 6. The absence of any "assertive outreach" to the deceased when discharged into the community (that is to say, no face to contact, no alternative welfare checks being organised, undue reliance being placed on the informal supervisory role of the landlord or other agencies) gave rise to a total disconnect between patient and healthcare provider, thereby creating a series of missed opportunities to assess the deceased, identify possible relapse signatures and potentially escalate care; 7. The circumstances of this case evidences a gap in the provision of care to a patient with a Dual Diagnosis in Lincolnshire by reason of there being no dedicated and/or commissioned drug and alcohol recovery team/service; 8. The Lincolnshire Partnership NHS Trust document – "Crisis Assessment and Home Team Protocol" (Exhibit reference IJ2) makes no adequate or appropriate provision for a patient with Dual Diagnosis; 9. The National Institute for Health and Care Excellence (NICE) Guideline Scope document "Severe mental illness and substance misuse (dual diagnosis): community health and social care services stipulates that there should be a Dual Diagnosis protocol setting out specifically the roles of the mental health provider and the drug and alcohol service provider (no such protocol being in place at the material time) and that whilst it is apparent that some thought has been deployed to re-install a bridge between mental health provision and drug and alcohol services this does not address the needs of a patient suffering from a complex Dual Diagnosis in Lincolnshire due to:

	a. The lack of interface between senior or experienced care providers to deal with multi-faceted or nuanced cases; b. The absence of specialist Dual Diagnosis workers to be deployed in complex cases; c. The absence of adequate and robust guidance and training, in particular for mental health practitioners to be aware of substance misuse issues and a patient suffering from Dual Diagnosis that impact on appropriate pathways of treatment and care;
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 19/10/2020. 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 Persons a) Dr [redacted] b) Mrs [redacted] I have also sent in to the following parties who may find it useful or helpful: Rt.Hon Matt Hancock MP Secretary of State for Health and Social Care House of Commons SW1A 0AA [redacted] Director of Public Health Lincolnshire County Council County Offices Lincoln

	LN1 1YL [redacted], Hospital Manager Cygnet Hospital Wyke Blankney Grange Huddersfield Road Wyke Bradford BD12 8LR Housing Department South Kesteven District Council Council Offices St. Peters Hill Grantham Lincolnshire NG31 6PZ 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.
	Date: 26/08/2020  Timothy BRENNAND HM Senior Coroner