Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 **All family members;**
2 **Dr [redacted] GP;**
3 **Change, Grow, live;**
4 **Nottinghamshire Healthcare NHS Foundation Trust; and**
5 **Nottinghamshire County Council.**

1 CORONER

I am Mr Gordon Clow, Assistant Coroner for Nottingham and Nottinghamshire. Gordon CLOW

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 Twenty-Seventh May 2020 I commenced an investigation into the death of Sean Daniel FEGAN aged 30. The investigation concluded at the end of the inquest on 25 March 2021. The conclusion of the inquest was that the death was:

Drug related

4 CIRCUMSTANCES OF THE DEATH

On or before the 26 April 2020, against a background of autism, complex mental health conditions and drugs misuse, Mr Sean Daniel Fegan took a combination of prescribed and illicit substances, notably [redacted] caused his death by means of toxicity. There was no evidence of third party involvement or of suspicion surrounding the death.

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. Decision making surrounding the need for secondary mental health care – as set out above, a decision was taken in December 2019 that Mr Fegan did not require mental health treatment at all in the absence of adequate information or assessment and for reasons which appeared incorrect.

2. Access to mental health treatment –Mr Fegan had complex mental health conditions and experienced very high levels of distress and anxiety as a consequence. He was declined mental health treatment on two occasions by the Trust. Mr Fegan took an overdose due to his frustration at not being able to access mental health services which he needed. Whilst this was not the cause of Mr Fegan's death, it created a dangerous state of affairs.

3. Dual diagnosis – it was acknowledged that there was a 'gap' within the services in relation to dual diagnosis patients. There was evidence of a resistance to agreeing to provide a service to patients with significant drugs misuse problems.

4. Liaison with family members – there was no evidence of proactive attempts to engage with family members, even when services withdrew. When a family member sought to share concerns, these were rebuffed.

5. Implementation of care plans – a care plan was devised by the liaison nurse and psychiatrist, only to be overruled by persons who had not themselves assessed Mr Fegan, on an incorrect basis, and without a review of the risk assessment justifying that decision. Mr Fegan was called and invited to agree to the withdrawal of services. Such a practice runs the significant risk that patients who are less assertive or who have poor insight into their mental health needs will be said to have 'agreed' that a service is no longer required.

6. Autism awareness – I was concerned that Mr Fegan's presentation acted as a barrier to a proper understanding of his mental health needs. In line with his autism diagnosis, he did not present in a socially typical way of expressing his feelings and emotions in a demonstrative manner, but rather 'jumped' to his view about what treatment he required, namely prescriptions. This was misunderstood by professionals on more than one occasion.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe that 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 20 May 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:-

1 All family members;
2 Dr [redacted], GP;
3 Change, Grow, live;
4 Nottinghamshire Healthcare NHS Foundation Trust; and
5 Nottinghamshire County Council.

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.

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Gordon CLOW
Assistant Coroner for
Nottingham City and Nottinghamshire
Dated: 25 March 2021