REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Secretary of State Department of Health and Social Care**
1	**CORONER** I am Nigel Parsley, Senior Coroner, for the coroner area of Suffolk.
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 6th February 2024 I commenced an investigation into the death of **Timothy Robert DE BOOS** The investigation concluded at the end of the inquest on 5th December 2024. The conclusion of the inquest was that the death was the result of:- **The effects of a self-ignited fire at his home address, whilst suffering a relapse of his known psychotic illness.** The medical cause of death was confirmed as: **1a Smoke inhalation and severe burns** **1b Domestic fire** **2 Paranoid schizophrenia, severe right coronary artery atherosclerosis**
4	**CIRCUMSTANCES OF THE DEATH** **Timothy De Boos was declared deceased at his home address in Ipswich, Suffolk on the 6th February 2024.** **Earlier that day a fire had to be seen coming from the ground floor flat of the address.** **Tim was seen by a witness to close the window of the flat whilst it was on fire, then disappear from view.** **Tim made no attempt to leave, and when found was sat or slumped against the door of the room.** **Timothy was known to the mental health services, and had a prolonged history of being mentally unwell (being diagnosed with paranoid schizophrenia in 2004), with evidence of a previous stated suicidal thought.** **A subsequent post-mortem examination identified that Tim had died from smoke inhalation and burns.**

	Although clearly able to do so Tim made no effort to leave the burning building, and on a balance of probabilities basis, deliberately remained inside with a view to ending his life Tim had suffered a mental health crisis on the 2nd February 2024 and Tim himself, Tim's family, and Tim's Mental Health Care Coordinator, all believed he should be admitted to a Mental Health Unit at that time as a voluntary patient. This could not be immediately actioned as a referral to another team was required, and members of that team who subsequently saw Tim the following day, deemed he was no longer in a mental health crisis. If Tim's admission to hospital had been actioned on the 2nd February 2024, he could not have been admitted in any event, as there was already a list of five other individuals waiting to be admitted to the same unit. Had Tim been admitted to a Mental Health Unit on the 2nd February 2024, his tragic death would not have occurred.
5	<u>CORONER'S CONCERNS</u> During the course of the inquest the evidence revealed matters given 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 as follows. – 1. I am concerned of the continuing lack of Mental Health Unit inpatient beds in Suffolk, and more widely throughout England and Wales. At the time of Tim's mental health crisis on the 2nd February 2024, had the decision to admit him been possible, he still would not have been admitted as there were five other individuals in the queue before him also waiting for admission. The lack of available beds is not a new problem, and I have previously issued two Regulation 28 Prevention of Future Death Reports in which a lack of inpatient Mental Health Unit beds have contributed to a death- Nicola Rayner (died 10th June 2023), reported 7th March 2024. Piotr Kierzkowski (died 17th December 2019), reported 12th October 2020. 2. In Tim's case, on the 2nd of February 2024 Tim's family, Tim himself, and Tim's Mental Health Care Coordinator (a Senior Mental Health Nurse who had been supporting Tim for a year), all wished for his admission to a Mental Health Unit as a voluntary patient. It was heard in evidence that a different team (the Crisis Resolution and Home Treatment Team) were the 'gatekeepers' for admission and this team could not review Tim until the next day. When reviewed by Crisis Resolution and Home Treatment Team staff (who had never met Tim before), they believed his crisis had subsided and his admission was denied. In evidence Tim's Mental Health Care Coordinator was adamant that Tim should have been hospitalised on the 2nd February, as both his family and Tim himself had also wished.

	I am therefore concerned that the views of an experienced mental health professional, a patient's family, and the patient themselves, is deemed insufficient evidence for an admission to a Mental Health Unit as a voluntary inpatient.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken in order to prevent future deaths, and I believe you or your organisation have the power to take any such action you identify.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 7th February 2025 I, the Senior Coroner, may extend the period if I consider it reasonable to do so. 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. Timothy's next of kin. 2. Norfolk and Suffolk Foundation Trust I am 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. She may send a copy of this report to any person who she believes may find it useful or of interest. You may make representations to me, the Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**13th December 2024**  **Nigel Parsley**