REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive** [redacted] **Norfolk and Suffolk NHS Foundation Trust** **Trust Headquarters** **Hellesdon Hospital** **Drayton High Road** **Norwich** **NR6 5BE**
1	**CORONER** I am William James Armstrong, Senior Coroner; for the area of Norfolk.
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 the 15th of May 2013 I commenced an investigation into the death of **Matthew Christopher Dunham**, who was 25 years old at the time of his death on the 9th of May 2013. The investigation concluded at the end of the inquest on the 4th of September 2013. It was found that the cause of death was multiple injuries as a result of a fall and the conclusion of the inquest was "Suicide whilst suffering from mental disorder and whilst in receipt of mental health services.
4	**CIRCUMSTANCES OF THE DEATH** Matthew Christopher Dunham, who was suffering from mental disorder and receiving professional mental health services at the time, leapt from the fifth floor of a shopping mall known as Castle Mall in Norwich. He fell to the ground. Assistance was provided straight away and medical attention given expeditiously. Sadly he could not be saved and was pronounced dead at the scene. Mr Dunham had been seen by various mental health professionals since February 2013 and had recently been expressing suicidal ideation.

5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern and, in my opinion, there is a risk that future deaths will occur unless action is taken. I fully accept that since this tragedy the Trust has instigated an internal review and is committed to taking a number of measures as a result of lessons learned from this tragedy. The **MATTERS OF CONCERN** are as follows. – a) An emergency referral by the general practitioner to the assessment team on the 4th of April 2013 was not followed up within the normal time scale of four hours and it was two days before a telephone triage session took place and four days before an assessment was undertaken by a mental health nurse. This raises the need to ensure that emergency referrals are dealt with within the appropriate time scale and that policies and procedures are in force to make sure that this happens. b) There appears not to have been a clear shared understanding between professionals as to which team it was appropriate to refer Mr Dunham too. There was some lack of understanding revealed as to whether a referral to the assessment team or the crisis resolution and home treatment team was appropriate. This highlights the need for there to be a clear understanding about the roles of each team and the interface between them. c) On the 8th of April 2013, despite the fact that Mr Dunham was presenting as feeling suicidal and specifically that he had set up a noose in his flat the previous night, it was not thought appropriate to refer him to the crisis team for appropriately robust intervention. This raises the issue of the basis upon which the risk of suicide or serious self harm is recognised and acted upon particularly where the person concerned has gone beyond vague suicidal ideation and moved towards contemplating some specific way of ending his life. d) A letter sent to Mr Dunham's general practitioner from the advice and assessment team was not drafted appropriately. This raises the issue of the need for specific guidance to be given about how such letters should be drafted within a template structure. e) Most disturbingly the evidence at the hearing displayed a lack of coordination between mental health professionals involved in Mr Dunham's care. Specifically when a mental health nurse saw Mr Dunham on the 8th of April he had no knowledge whatsoever that Mr Dunham was already being seen by a psychological wellbeing practitioner. This clearly demonstrates the need for effective information sharing between professionals involved in managing the care of a mentally ill person and the need for each and every professional to have access to all the records relating to the patient and details of interventions and actions by other practitioners. It is recognised that the Trust is working towards the implementation of a single electronic health record in 2014. N.B. It is fully recognised that the Trust has commendably committed itself to learning lessons as a result of this tragedy. However, the inadequacies revealed in what I described at the inquest as the "fragmented and uncoordinated" approach to Mr Dunham's care clearly demonstrate the need for these issues to be addressed speedily and comprehensively in the interests of seeking to reduce the possibility of further fatalities.

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 60 days of the date of this report, namely by 11 November 2013. 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: [redacted] (mother) [redacted] Spixworth Norwich NR10 [redacted] [redacted] (father) [redacted] Stanfield Wymondham NR18 [redacted] [redacted] Quality and Patient Safety Manager, NHS Anglia Commissioning Support Unit Lakeside 400 Old Chapel Way Broadland Business Park Norwich NR7 0WG Healthwatch Norfolk The Business Base Ltd Rowan House 28 Queens Road Hethersett Norwich NR9 3DB Derek Winter (Archivist) HM Coroner for the City of Sunderland Civic Centre Burdon Road Sunderland SR2 7DN 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.
9	**12 September 2013**