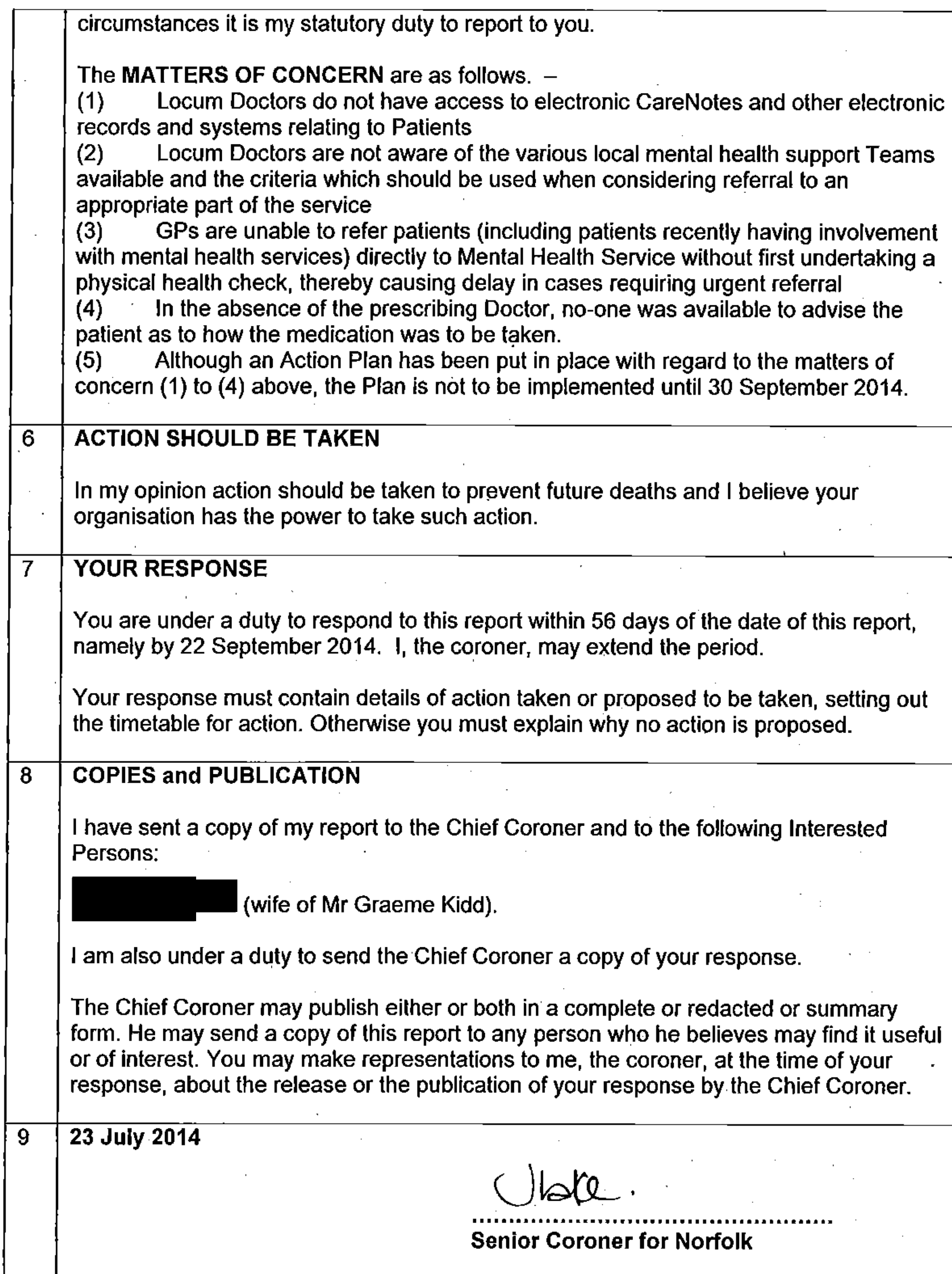
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*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** **Norfolk and Suffolk NHS Foundation Trust** **Trust Headquarters** **Hellesdon Hospital** **Drayton High Road** **Norwich** **NR6 5BE**
1	**CORONER** I am JACQUELINE LAKE, senior coroner, for the coroner 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 7 March 2014 I commenced an investigation into the death of Graeme Alexander Kidd, age 42 years. The investigation concluded at the end of the inquest on 16 July 2014. The medical cause of death was 1a) cardiogenic shock and hypoxic brain injury, 1b) Asphyxiation from hanging by the neck. The conclusion of the inquest was "Suicide whilst the balance of his mind was disturbed and whilst under the care of the mental health services".
4	**CIRCUMSTANCES OF THE DEATH** Mr Kidd lived with his wife and children. He had a history of mental illness in 2003, which resurfaced in 2008/2009 and in 2010. There had been previous attempts at self harm and to take his own life. Mr Kidd became anxious and down in 2013 and went to his GP, who restarted medication and referred Mr Kidd as an urgent case to mental health services. Mr Kidd was referred to the Crisis & Home Treatment Team. He was discharged on 6 January 2014. Mr Kidd returned to his GP on 2 occasions and was re-referred to mental health services. He was seen by Consultant Psychiatrist on 21 February and it was decided to wait to see how a previous increase in medication worked. Mr Kidd telephoned the Psychiatrist on Friday 28 February 2014 with low mood and it was agreed he would see how he fared over the weekend. Mr Kidd telephoned Monday 3 March 2014 when it was agreed his medication would be further increased. Mr Kidd collected the prescription on 5 March. He telephoned Mental Health Services later that day as he was unclear as to how to take the medication. He was to be telephoned back later that day. An attempt was made to telephone Mr Kidd on 6 March 2014. On 6 March 2014 Mrs Kidd returned home after taking the children to school and found her husband hanging. He was taken to hospital and died on 7 March 2014.
5	**<u>CORONER'S CONCERNS</u>** 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) Locum Doctors do not have access to electronic CareNotes and other electronic records and systems relating to Patients (2) Locum Doctors are not aware of the various local mental health support Teams available and the criteria which should be used when considering referral to an appropriate part of the service (3) GPs are unable to refer patients (including patients recently having involvement with mental health services) directly to Mental Health Service without first undertaking a physical health check, thereby causing delay in cases requiring urgent referral (4) In the absence of the prescribing Doctor, no-one was available to advise the patient as to how the medication was to be taken. (5) Although an Action Plan has been put in place with regard to the matters of concern (1) to (4) above, the Plan is not to be implemented until 30 September 2014.
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 56 days of the date of this report, namely by 22 September 2014. 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: (wife of Mr Graeme Kidd). 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	**23 July 2014** .... **Senior Coroner for Norfolk**