REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	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 29 September 2014 I commenced an investigation into the death of Mark Robert Anstice, aged 38 years. The investigation concluded at the end of the inquest on 13 January 2015. The conclusion of the inquest was medical cause of death: 1a) Fatal compression to the neck and narrative conclusion: Mr Anstice hanged himself. His intention at the time is not known.
4	**CIRCUMSTANCES OF THE DEATH** Mr Anstice had a history of mental health and social problems, leading to previous self harm. He moved to Norfolk in 2012. Towards end 2013/beginning 2014 his mental health deteriorated with feelings of isolation. He became more withdrawn. In July 2014 he considered taking his own life and was referred to the Access and Assessment Team (AAT). Due to further problems, he was assessed under the MH Act on 3 August 2014. He was seen by Psychiatrist on 12 August 2014, who recommended a Support Worker/Care Co-Ordinator and review. There was an overdose on 27 August 2014, when he was admitted to WSH as a voluntary patient. He was discharged 3 September 2014, to Bury North IDT. Mr Anstice did attend a Group Session on 5 September 2014, but otherwise was not spoken to by Bury North IDT despite attempts made to telephone on 5 and 8th September 2014. Mr Anstice did not attend a Group Session on 12 September 2014. On 17 September 2014, Mr Anstice was discharged from Bury North IDT to the care of GP. An Appointment with the Psychiatrist was brought forward to 8 October 2014 at request of Mr Anstice's partner. On 25 September 2014 Mr Anstice was reported as a missing person. He was found hanged on 27 September 2014.
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) On 12 August 2014 Psychiatrist recommended Mr Anstice would benefit from a Support Worker and/or Care Co-Ordinator – this was not actioned. The reason for this is not known – it was indicated this may be due to an administrative problem; (2) It was recommended a referral be made for a Carer's Assessment on 1 September 2014. It is not clear this referral was made. Even if it had been made there would be difficulties with assessment and provision of the service in view of the fact Mr Anstice resided in Norfolk and the service would be provided by Suffolk MH Team (3) The appointment arranged with the Psychiatrist for 12 November 2014 was not known by other members of the Team, despite Team Meetings being in place to discuss Mr Anstice's care. (4) It was recommended to Mr Anstice he attend Group sessions to help overcome feelings of social isolation, whilst being unaware as to whether Mr Anstice was physically able to attend those Group sessions. He did not have the transport or means to attend such groups. (5) When it became known to the IDT that Mr Anstice did not have the transport or means to attend the Groups, consideration was given as to how to help him overcome those practical difficulties but Mr Anstice was not informed that help was being considered. (6) Mr Anstice was discharged from Bury North IDT on 17 September 2014, being invited to attend Groups and having attended one on the 5 September 2014. However IDT were unable to speak with Mr Anstice by telephone on 5 September 2014, 8 September 2014 (tried 3 times) and he did not attend Group session on 12 September 2014. (7) At the time of Mr Anstice's discharge from Bury North IDT, IDT were unaware Mr Anstice had an appointment with a Psychiatrist on 12 November 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 13 March 2015 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] (Partner) [redacted] (Father) 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	**16 January 2015** **……..** **Senior Coroner for Norfolk**