


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: 1. North Bristol NHS Trust
1	CORONER I am Maria Voisin, Senior Coroner, for the area of Avon
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 11 th June 2014 I commenced an investigation into the death of Sian Leigh ARMSTRONG , Aged 17. The investigation concluded at the end of the inquest on 14 th January 2015. The conclusion of the inquest was as follows: <u>Medical Cause of Death</u> 1a) Hanging <u>Conclusion</u> Sian Armstrong had a history of depression, she was under the care of the mental health service and on the balance of probability took her own life.
4	CIRCUMSTANCES OF THE DEATH Sian had a history of depression. In March 2014 she made an attempt on her life by way of an overdose. Following this she had been seen by the Mental Health Team. Sian was assessed as needing to receive CBT but from the time of the assessment in March 2014 until her death in June 2014 she had not received CBT
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. There was a delay in Sian receiving CBT which she was assessed as requiring. 2. At the inquest I indicated that I would ask North Bristol NHS Trust for reassurance that steps will be taken to ensure that this therapy is available to children who are assessed as needing it in a timely manner
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you have 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,

	<p>namely by 18th March 2015. I, the Coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons – the family - and to the LOCAL SAFEGUARDING BOARD.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>21.1.15</p> <p>M. E. Voisin</p> <p></p>