REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Chief Executive Norfolk and Suffolk NHS Foundation Trust **Trust Management** 1st Floor Admin Hellesdon Hospital **Drayton High Road** Hellesdon Norwich NR6 5BE CORONER I am JACQUELINE LAKE, senior coroner, for the coroner area of NORFOLK 2 **CORONER'S LÉGAL 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. INVESTIGATION and INQUEST On 17 November 2014 I commenced an investigation into the death of Barbara Mary Anne Mayer Aged 72 years. The investigation concluded at the end of the inquest on 11 March 2015. The conclusion of the inquest was medical cause of death: drowning, and conclusion: "Suicide whilst under the care of Mental Health Services". CIRCUMSTANCES OF THE DEATH Mrs Mayer had a long history of depression. Her anxiety increased in 2013 when she suffered a number of physical health problems. She was reviewed regularly by her GP who referred her for a mental health assessment in September 2014. Her care was passed to the Dementia and Complexity in Later Life Team. She continued to ask her husband to help her end her life. She was discharged by the Crisis Team to the Community Mental Health Team on 15 October 2014. Her GP referred her back to the Crisis Team for assessment on 12 November 2014. On 14 November 2014, Mrs Mayer begged her husband to help drown her in the bath. called the Crisis Team who were unable to attend due to levels of work elsewhere. Her Care Co-Ordinator did attend to see her. was contacted by the Crisis Team to say someone would be visiting that day. At 21:15 hours a telephone call was made to say someone would attend after midnight for an assessment. As Mrs Mayer had taken sleeping medication and was getting ready for bed, it was agreed someone would call to see her the next morning. At some time between 02:00am and 05:00am Mrs Mayer left the house. leaving a pillow in her bed in place of her body. She was found on 16 November 2014 drowned in a nearby pond. 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. was noted to show signs of Carer fatigue, but this was not followed

-	up; (2) Although seen regularly by the Crisis Team, Mrs Mayer was seen by a number of different people as a result of which no trusting relationship could be established. She had to repeat her history at each visit to a different person about personal matters. (3) Different treatments were offered to Mrs Mayer without the reasoning or their efficacy being discussed with her. (4) Mrs Mayer required help urgently on 14 November 2014 but due to an increase in demand no one was available to see her until 16 November 2014. It is understood Doctors are now called out and an On call Manager can be contacted in such situations.
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 May 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 Person:
÷	Mayer (husband).
	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	DATE: 23 March 2015 SIGNED BY CORONER