REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • **Mr Simon Stevens, Chief Executive, NHS England** • **Ms. Jackie Smith, Chief Executive, Nursing & Midwifery Council**
1	**CORONER** I am Christina JL Swann, Assistant Coroner for the area of Leicester City and Leicestershire South.
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 13th June 2016 I commenced an investigation into the death of Benjamin Orrill. The Inquest concluded on 19th September 2016 Cause of death: 1a Multiple injuries Conclusion: Suicide
4	**CIRCUMSTANCES OF THE DEATH** Mr. Orrill died on 12th June 2016 following a fall from Lee Circle NCP car park, Leicester. He had been reviewed by an advanced nurse practitioner in the weeks leading up to his death due to feeling suicidal. There was a missed opportunity to appropriately assess the severity of Mr. Orrill's low mood, however there was no evidence heard to suggest that this would have prevented the outcome. Police investigation concluded that there were no suspicious circumstances, that these were Mr. Orrill's own actions and that he did intend the outcome.
5	**CORONER'S CONCERNS** During the course of the Inquest it came to my attention that there is no regulatory body for advanced nurse practitioners. It would appear they are not subject to the same stringent appraisal and revalidation processes such that GPs currently are, despite the fact that they may perform similar duties and can have parallel roles. I also became aware that some advance nurse practitioners may independently buy into a partnership and may not have an employer directly responsible for their appraisal. Therefore some may potentially be operating as independent practitioners without any supervision or regulation. I am concerned that this may have a significant impact on patient safety.

1.	**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, namely by 14th December 2016. 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] (Father) • The Fosse Medical Centre 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	**19th October 2016** **Dr Christina JL Swann**