ANNEX A

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:** **North Essex University NHS Foundation Trust**
1	**CORONER** I am Caroline Beasley-Murray, senior coroner, for the coroner area of Essex
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 2 March 2016 I commenced an investigation into the death of Melanie Ellen Lowe. The investigation concluded at the end of the inquest on 9 November 2016. The conclusion of the inquest was that Melanie Ellen Lowe killed herself. The jury added a narrative conclusion – *Melanie's risk of self harm/suicide was not properly and adequately assessed and reviewed. Adequate and appropriate precautions were not taken to manage her risk of self harm/suicide*
4	**CIRCUMSTANCES OF THE DEATH** Melanie Lowe, a 41 year old lady had suffered from somatization disorder over a long period of time and was sectioned under s2 MHA in the Derwent Centre Harlow. On the morning of 2 March she was found unresponsive in her room and she was found to have a wad of tissues obstructing her airway. She died in Princess Alexandra Hospital Harlow later that day. Both the trust's own Serious Incident Investigation report and the independent psychiatric report provided by an independent psychiatrist instructed by the court were highly critical of the care provided to Melanie in the time leading up to her death
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) The trust's action plan is very basic, lacking specific detail. Some elements are blank and there is an absence of supporting evidence. A far more rigorous action plan is required in an effort to prevent future deaths such as Melanie's. Cont......

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 16th January 2017. 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 – solicitors for the family. 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	**11 November 2016** **Caroline Beasley-Murray**