


## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <p><b>Chief Executive Norfolk &amp; Suffolk NHS Foundation Trust Hellesdon Hospital Drayton High Road Norwich NR6 5BE</b></p>
1	<p><b>CORONER</b></p> <p>I am JACQUELINE LAKE, Senior Coroner, for the coroner area of NORFOLK</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 15 November 2016, I commenced an investigation into the death of BENJAMIN THOMAS GOODRUM, AGED 35. The investigation concluded at the end of the inquest on 5 DECEMBER 2017. The conclusion of the inquest was medical cause of death: Unascertained and Conclusion: Open</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Mr Goodrum was diagnosed with Schizophrenia and Asperger's syndrome. He lived in the community and received support from his parents, Norfolk County Council, MIND, and NSFT. He was under the Long Treatment Team (NSFT) and was due to receive a depot injection once per month. There were difficulties engaging with Mr Goodrum by the organisations and by his family. Mr Goodrum was last seen by support workers on 24 May 2017 and by his father 4 weeks prior to his death. His last telephone call was recorded as being on the 16 June 2017. Mr Goodrum was found in his flat clearly deceased on 27 June 2016.</p>
5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <p>(1) Although there was evidence of good communication between the various organisations involved with Mr Goodrum and attempts were ongoing to retain contact with him, there was no one person taking overall responsibility for Mr Goodrum.</p> <p>(2) Mr Goodrum had originally been allocated a Care Co-Ordinator but on this person leaving, no new Care Co-Ordinator was appointed.</p> <p>(3) The Serious Incident Investigation recommended all service users receiving active treatment should be allocated a Lead Care Professional or a Care Co-Ordinator and this action was to be completed by 30/04/2017. At the time of the inquest this action had not been put in place and the Action Plan was regarded as complete.</p>

	<p>(4) Evidence was heard that alternative measures have been taken within the various teams to ameliorate the lack of sufficient Care Co-Ordinators for service users, for instance using a team-based approach, but that such measures are not as effective as service users having a specific individual appointed as a Care Co-Ordinator.</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 5 February 2018. 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><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <p>██████████ MIND Norfolk County Council</p> <p>I have also sent it to the:</p> <p>Care Quality Commission &amp; Healthwatch Norfolk who may find it useful or of interest.</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>8 December 2017</p> <p style="text-align: right;">   .....  <b>Jacqueline Lake</b>  <b>Senior Coroner</b>  <b>Norfolk Coroner Service</b>  <b>69-75 Thorpe Road</b>  <b>Norwich NR1 1UA</b> </p>