REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NORFOLK & SUFFOLK NHS FOUNDATION TRUST**
1	**CORONER** I am JACQUELINE LAKE, senior coroner, for the coroner area of NORFOLK
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 15 November 2016 I commenced an investigation into the death of BRIAN STANNARD, AGED 64 YEARS. The investigation concluded at the end of the inquest on 26 OCTOBER 2017. The conclusion of the inquest was Medical Cause of Death: 1a) Drowning and Conclusion: Mr Stannard was found drowned on the beach at Gt Yarmouth but the evidence does not fully explain whether he intended that the outcome be fatal.
4	**CIRCUMSTANCES OF THE DEATH** Mr Stannard was a resident at Eversley Nursing Home at Gt Yarmouth. At approximately 5.30 am on 14 November 2016 Mr Stannard was seen by Carers in his room asleep. Noises were heard on the floor of Mr Stannard's bedroom. The evidence does not reveal whether the noises heard were investigated. At about 6.50 am that morning a body was found on the beach at Gt Yarmouth which was identified as that of Mr Stannard. Mr Stannard was declared dead at the scene. The evidence does not reveal how Mr Stannard left the Home and got to the beach area.
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. – (1) Mr Stannard had mental ill health and physical ill health. He was placed at a Nursing Home to manage his physical ill health as this was seen as the priority at the time of admission. Staff at the Home were not adequately equipped to deal with his mental ill health as his physical health improved. This not only raises concern with regard to the safety and well-being of the individual concerned, but also with regard to the staff involved in Mr Stannard's care. They were not trained mental health individuals and were required to deal with attempts at and threats of self-harm and suicide by Mr Stannard. There did not appear to be a Home available where staff were adequately trained to deal with a person's mental and physical ill-health. (2) Records of staff were not always completed or fully completed. Staff are now provided with laptops to aid flexibility with regard to record keeping. It is understood staff are now required to complete their records by the end of each shift. Due to the volume of work, it is not clear if members of staff are given sufficient time and space to see the service user and then to write up their records during the same shift.

	(3) Due to volume of work, some staff may be completing their records in their own time. (4) The Lorenzo computer system was brought in some years ago. It does not appear to be fully operational and used to its full potential by all staff.
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 15 January 2018. 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] (son) (son) Eversley Care Home Care Quality Commission Healthwatch Norfolk 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	**14 November 2017** **[SIGNED BY CORONER]**