Tony Williams
Senior Coroner for Somerset

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: South London and Maundsley NHS Foundation Trust**
1	**CORONER** I am Tony Williams, Senior Coroner for Somerset
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 24/08/2016 I commenced an investigation into the death of Edward Arthur Lundy, 23 . The investigation concluded at the end of the inquest on 05/12/2017. The conclusion of the inquest was "Suicide. During the course of diagnosis and treatment Edward Lundy was not seen by a psychiatrist, care options were not documented and discussed with family members and he was seen by numerous different health care professionals". I recorded that on 23rd August 2017 at West Combe Farm, Huish Champflower Edward Lundy deliberately suspended himself by the neck with the intention of ending his life.
4	**CIRCUMSTANCES OF THE DEATH** Edward had a history of depression. He had been staying with a friend's family and was last seen alive when he went for a walk at about 10:00 hours on 23.08.16. The friend's mother went looking for him and found him hanging by the neck from a rope secured to a beam in a barn in a field on the family farm. He had secured wrists together in front of him with a cable tie. A note was also discovered at scene with his rucksack and a sports bottle containing alcohol. He was cut down and given CPR whilst ambulance was called but could not be revived.
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. – The South London and Maundsley NHS Foundation Trust ('The Trust') completed it's own Mental Health Investigation Report under the NHS England Serious Incident Framework. The investigation was conducted by [redacted] Consultant Liaison Psychiatrist, St Thomas' Hospital and [redacted] Team Leader of Lewisham PMIC Treatment Service. The Report acknowledges that Edward Lundy was known to the Trust since 15th July 2016 being reported initially to Lambeth Assessment and Liaison Team and then to the Lambeth Living Well Network Hub where Edward was seen twice on 10th and 18th August 2016. Lambeth Hub contacted Wandsworth IAPT with a view to requesting that psychological therapy be re-started and an appointment was made for 24th August 2016. The Trusts own findings identified a number of issues and a number of proposed actions. 1. Edward Lundy had contact with many professionals in a short period of time and that affected the continuity of his care. Proposed action to set up joint services review with

Old Municipal Buildings, Corporation Street, Taunton, Somerset, TA1 4AQ
Tel 01823 359271 | Fax 01823 355060

	provider organisations involved with an oversight report to be produced. 2. That upon Edward Lundy's discharge into the care of his family, there should have been independent consultation with the family and this should have been documented with the risks being explicitly discussed. Proposed action to ensure that the Psychiatric Liaisons Operational Policy stated as such and to disseminate to all liaison teams via pathway meetings and local business meetings. 3. That the doctor referring Edward to the Lambeth Assessment and Liaison Team should have made it clear that he believed Edward should be seen by a psychiatrist. Proposed action that the Training Lead in the Trust be informed that GP trainees should receive risk management training, focussing on crisis intervention services e.g. when to consider CMHT/Home Treatment Team/Inpatient Admission. There has been no evidence produced as to compliance with the recommended actions. There has been no evidence produced as to the findings of the report and its proposed actions being started nationally so as to inform other Mental Health Trusts. That the family received no information as to the proposed actions having been followed through and any resultant changes in procedure.

6	**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 05 December 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 [redacted] (Edward's Parents). 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	Dated 21 March 2018 Signature Senior Coroner for Somerset

Old Municipal Buildings, Corporation Street, Taunton, Somerset, TA1 4AQ
Tel 01823 359271 | Fax 01823 355060