REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used after an inquest.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	1. Chief Executive Norfolk and Suffolk NHS Foundation Trust
1	CORONER
	I am Dr Séan Cummings Assistant Coroner for the Coroner Area of London (Western Area)
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 the 5 th July 2016 an Inquest was opened into the death of Henry Curtis-Williams. The investigation concluded at the end of the inquest on the 7 th November 2018. The conclusion of the inquest was (2) Hanging (4) Suicide
4	CIRCUMSTANCES OF THE DEATH
	Henry Curtis-Williams died from hanging at Acton Cemetery on the 17 th May 2018. He had been admitted to the Woodlands Unit on the 11 th May 2016 under police section 136 after he was found contemplating jumping off the Orwell Bridge in Ipswich. He was transferred to nearby Southgate Ward after a mental health assessment. He was discharged the next day without a Consultant review. He travelled to London where he was attending University and was seen and comprehensively assessed by his GP. He died sometime later.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you.
	The MATTERS OF CONCERN are as follows. —
	 That following admission to Southgate Ward Henry Curtis-Williams was seen by a number of different staff members. It became evident that there was a culture of not recording contemporaneous notes. This was very obvious with reference to recording presence or absence of suicidal ideation. There was an acceptance that patients could be discharged by very junior doctors without prior reference to Consultant or Senior colleagues even though Henry had been admitted after being assessed by 2 Section 12 approved doctors and an Approved Mental Health Professional who felt he needed a prolonged inpatient stay. Communication between staff members was very informal with no record

kept of important messages relayed. For example, the member of staff who held a one to one meeting with Henry was not present at the ward round where Henry's case was discussed but said she had verbally passed a message to the ward round nurse. This was normal practice on this ward. There was no record of the message, or of it being passed or that it was considered at the ward round. **ACTION SHOULD BE TAKEN** 6 In my opinion action should be taken to prevent future deaths and I believe you the Chief Executive of Norfolk and Suffolk NHS Foundation Trust have the power to take such action. YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report. namely by 12th February 2019. 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. COPIES and PUBLICATION I have sent a copy of my report to the Chief Coroner and to the following Interested Persons (1) Henry's mother and father, 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. Dr Séan Cummings Assistant Coroner 19th December 2018