Regulation 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

The Chief Executive
Norfolk & Suffolk NHS Foundation Trust
Drayton High Road
Hellesdon
Norwich NR6 5BE

1 CORONER

I am Jacqueline LAKE, Senior Coroner for the 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 13/12/2017 I commenced an investigation into the death of Ellie Jane LONG, aged 15. The investigation concluded at the end of the inquest on 16/01/2019. The conclusion of the inquest was: Ellie Long took action to end her own life. The evidence does not reveal whether she intended to die.

The medical cause of death was:

1a	Hypoxic Brain Injury
1b	Cardiac Arrest
1c	Hanging
II	Anorexia, Depression

4 CIRCUMSTANCES OF THE DEATH

Ellie Long was receiving treatment in the community from the Eating Disorder Service. She was diagnosed with Anorexia Nervosa and Depression. On the morning of 10 December 2017, Miss Long went to her bedroom, where she was found hanging later that morning. Emergency Services were called, and Miss Long was taken to Norfolk and Norwich University Hospital where she died on 12 December 2017.

5 CORONER'S CONCERNS

During the course of the inquest, the evidence revealed matters giving rise to concern. These were dealt with by way of written representations submitted on behalf of IPs. Some of the concerns raised have been dealt with and I propose taking no further action. However, as indicated in Court today, 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. Record keeping and Auditing of Record keeping

a) Not all records were properly recorded on Lorenzo. Further, personal handwritten notes were made of some meetings which were not then reflected in the electronic records. Some of these notes only came to light during the inquest hearing. It is, of course, imperative that all staff recognise their obligations in respect of keeping full and contemporaneous electronic records and that full disclosure of all relevant documents is made in a timely fashion before the inquest commences. This avoids potential delay in the inquest process and further distress to the family.

b) Some action has been taken by NSFT in this respect, not least in that the team is now better resourced staff-wise. Further action has been and is being taken to ensure staff appreciate the importance of full record keeping. An audit of the records has been undertaken to ensure full compliance with record keeping requirements but this will only continue until 100% compliance has been achieved.

c) Concern remains in that staff do change over time and matters raised now do not necessarily remain at the forefront of an individual's mind, especially when under time pressure. Good record keeping is an integral part of any good service and must be second nature to all staff. It must be fully appreciated by all as "a *vital component in the management of risk*". Further, record keeping has been raised elsewhere as a matter of concern within NSFT.

d) I have concern that full record keeping and disclosure requirements will not remain a priority.

2. Communication with External Agencies

a) An initial full, updating letter was sent to Ellie's GP. However no further updating information was sent. A letter was written providing updating information, but this was not sent. No further updating information was sent to the GP by telephone, letter or email.

b) The evidence heard is that efforts were made to contact the school by telephone. However, the school had no record of any such calls. There is no evidence of email or written correspondence or further telephone calls in an effort to communicate with the school.

c) It is accepted by the Trust that sharing of relevant information is necessary. NSFT has indicated it will "*remind staff of the importance of recording efforts to share information/maintain communication*".

d) Sharing of information and communication with external agencies is a matter which has been raised with NSFT on previous occasions. The importance of "*recording efforts to share information ...*" may not be sufficient to prevent future deaths. It is the importance of sharing information and communicating with external agencies that should be addressed here. Recording of information is dealt with at Point 1 above.

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 13 May 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.

8 COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

[redacted] mother

I have also sent it to

Norwich Clinical Commissioning Group
Norfolk Child Death Overview Panel, Norfolk County Council
Norfolk Local Safeguarding Board
[redacted], Educational Psychology: Specialist Support, Children's Services Department
[redacted] Norfolk Constabulary Legal Services
[redacted] Wymondham Medical Practice

who may find it useful or of interest.

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: 18/03/2019

JLake.

Jacqueline LAKE
Senior Coroner for Norfolk
Norfolk Coroner Service
Carrow House
301 King Street
Norwich NR1 2TN