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
HELLESDON HOSPITAL
DRAYTON HIGH ROAD
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 29/05/2018 I commenced an investigation into the death of Nyall Cye BROWN aged 19. The investigation concluded at the end of the inquest on 12/04/2019. The conclusion of the inquest was: Mr Nyall Brown hanged himself. The medical cause of death was: 1a Hypoxic Brain Injury 1b Asphyxia
1c Hanging II Depression

4 CIRCUMSTANCES OF THE DEATH

Mr Brown was taken to hospital following his being found hanging in woodland on 29 January 2018. Mr Brown was discharged from Mental Health Trust care on 8 March 2018. On 17 May 2018 Mr Brown was found hanging in woodland following his sending a text message indicating his whereabouts. Mr Brown was taken to Norfolk and Norwich University Hospital where he died on 22 May 2018.

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. Evidence was heard that Mr Brown's care records were not reviewed prior to his being seen, which would enable Mr Brown's full history and risks to be taken into account when assessing him.
2. This is a matter which has been raised with the Trust previously. Staff are expected to read previous records relating to a service user, but this is not always happening.
3. This matter was not considered in the otherwise thorough investigation conducted by the Trust.

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 10 June 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

- 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: 15/04/2019

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