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 30/07/2018 I commenced an investigation into the death of Tamsin Rebecca Lianne GRUNDY aged 23. The investigation concluded at the end of the inquest on 13/03/2019. The conclusion of the inquest was: Suicide. The medical cause of death:

1a Compression of the Neck by a Weightlifting Bar
1b
1c
II

4 CIRCUMSTANCES OF THE DEATH

Miss Grundy had a history of depression and had previously made attempts to end her own life. Miss Grundy was under the care of the Mental Health Services at the time of her death. On 26 July 2018 Miss Grundy was alone at home. She was later found with a weightlifting bar across her neck. Emergency services were called and she was pronounced dead at the scene.

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.Miss Grundy repeatedly spoke about her concern about the number of people involved in her care, particularly from the Crisis Resolution Home Treatment Team. It is understood Miss Grundy saw 25 plus members of the Team in some 14 months. The evidence was that she found it difficult to relate to so many people, having to repeat the difficulties she was experiencing which she felt was adversely impacting on her mental health. It was not clear from the evidence that this issue was addressed during Miss Grundy's contact with the service.

2. This issue is referred to in the Serious Incident Requiring Investigation Report, having been raised by Miss Grundy's family, but there is no definitive, timed action arising from it and no named person responsible for any such action.

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 08 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)
Clinical Commissioning Group (West Norfolk)

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: 13/03/2019

J Lake.

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