Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

Chief Executive
Norfolk & Suffolk NHS Foundation Trust
Hellesdon Hospital
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 15/03/2019 I commenced an investigation into the death of Theo Jude BRENNAN-HULME aged 21. The investigation concluded at the end of the inquest on 09/02/2022. The medical cause of death was:

1a) Hanging by the Neck
1b)
1c)
1d)
2

The conclusion of the inquest was: Suicide. The mental health assessment carried out on 28 February 2019 was inadequate.

4. CIRCUMSTANCES OF THE DEATH

Theo Brennan Hulme had a diagnosis of Asperger's Syndrome and a history of deliberate self-harm. Theo was a student at the University of East Anglia from September 2018. He referred himself to the Wellbeing Team on 25 September with low mood and depression and he attended Norfolk and Norwich University Hospital on 26 September 2018 with a history of self-harm and suicidal thoughts. Contact was made with Theo's mother who came to be with Theo who decided to continue at university. He was referred to the Youth Mental Health Team. Theo was discharged from the service without being seen or spoken to. On 26 January 2019 Theo became distressed and had thoughts of suicide following his taking drugs and consuming alcohol. An appointment with the Wellbeing Service arranged for 31 January 2019 was cancelled due to staff sickness and rearranged for 6 March 2019. On 28 February 2019 Theo sought help from the University General Practitioner Service and was referred as an emergency to the community Mental Health Service. He had had thoughts of stabbing himself or drinking bleach. The referral time for an emergency is 4 hours. Theo was seen at 8 hours due to service demands. He was assessed at Hellesdon Hospital. Theo presented with a deterioration in his mental state and with suicidal ideation. He was concerned about his future accommodation, relationships and his university workload. The assessment took at most 41 minutes. Reasonable adjustments were not made to take into account Theo's diagnosis of Asperger's Syndrome, contact was not made with Theo's family and he was not referred to the Mental Health Home Treatment Team to enable treatment options to be explored. Theo did not attend the Wellbeing Service appointment on 6 March 2019. This was not followed up by the Service. On 9 March Theo exchanged text messages and attended a social event when he did not indicate his intention to take his own life. On 12 March 2019 Theo's room was forcibly entered following concerns being raised for his welfare. Theo was found hanging and was declared 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 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:

1. Evidence was heard of a historic culture of bullying and harassment within the Crisis Resolution Home Treatment Team which has led to a loss of compassion in some instances with the view that some suicides are “inevitable” and some reluctance to recognise when cases should be referred to the Team. Work has been undertaken by the Trust to improve such cultural attitudes. However, it was recognised in evidence that there is “still a distance to go” and areas where the culture needs to change. It is of concern that this culture remains three years following Theo’s death
2. Following an Assessment, a person is still discharged from the Community Team without any immediate “check” or discussion as to the correctness of this decision. It was heard that following Theo’s death immediate discharge from the Community Team following assessment is relatively rare. In these circumstances, such a discussion would not place an onerous burden on the Team and would enable a review of the discharging decision to be undertaken to ensure it is the correct decision.

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 April 2022. 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] parents via their solicitor.

University of East Anglia.

I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

I may also send a copy of your response to any other person who I believe may find it useful or of interest.

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.

9. Dated: 15 February 2022

Jacqueline LAKE
Senior Coroner for Norfolk
Norfolk Coroner Service
County Hall
Martineau Lane
Norwich NR1 2DH