Dr Roy Palmer
Assistant Coroner for City of London

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Mr Tom Cahill** Head Office, Hertfordshire Partnership University NHS Foundation Trust The Colonnades, Beaconsfield Road, Hatfield, Herts AL10 8YE
1	**CORONER** I am Dr Roy Palmer, Assistant Coroner for City of London
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 12/05/2016 I commenced an investigation into the death of Nathan Anthony Lowe, 45. The investigation concluded with a medical cause of death given as 1a) multiple injuries including skull fracture. At the inquest held on 19 August 2016, the conclusion was Suicide.
4	**CIRCUMSTANCES OF THE DEATH** Nathan LOWE was discharged from a Section 2 Mental Health Act Order and from Hospital on or around 9th October 2015. He was to be followed up in the community by a psychiatric nurse The last "face to face" contact between the patient and nurse was on 10th March 2016. Mr Lowe fell to his death in central London on 12th May 2016. The psychiatric nurse made several attempts to contact Mr Lowe between 10th March and 12th May including a referral to the multidisciplinary team and through the Multi Agency Public Protection Arrangements team
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. – Whether or not more should have been done to make contact with the patient between 10th March and 12th May given the nature of his illness and the fact of his non-compliance with follow up. Such consideration is relevant to a Coroner's duty in connection with the prevention of future deaths

City of London Coroner's Court, Walbrook Wharf, 78-83 Upper Thames Street, London, EC4R 3TD
Tel 020 7332 1598 | Fax 020 7332 1800

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Mr Tom Cahill have 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 19th October 2016. 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; Mr Tony Lowe, Mrs Jenny Lowe, Legal services for the relevant health trust (Hertfordshire Partnership University NHS Foundation Trust) 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 19 August 2016 Signature_____ Assistant Coroner for City of London

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