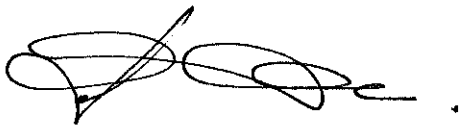
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Chief Executive, Central and North West London (CNWL) NHS Foundation Trust, Trust Headquarters, Executive Office, 350 Euston Road, London. NW1 3AX
1	**CORONER** I am Professor Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West 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.
3	**INVESTIGATION and INQUEST** On the 27th April 2021, 22nd and 23rd November 2022, evidence was heard touching the death of Nicola Norman. She had died on 20th January 2020, aged 42 years. **Medical Cause of Death** 1 (a) Asphyxia (b) Suspension by neck 11 **How, when, where the deceased came by her death:** Nicola had a 20 year history of mental illness and had been diagnosed with Emotionally Unstable Personality Disorder. From around November of 2019 she suffered a sharp decline, developing depression, anxiety and somatisation. Between December 2019 and January 2020she self-harmed on multiple occasions. Despite care of the primary health services and secondary health services, 20/01/2020 at approximately 10:30, she was found dead hanging at her mother's address and recognised life extinct by the London Ambulance Service. There were no suspicious circumstances. **Conclusion of the Coroner as to the death:** She took her own life whilst suffering severe and enduring mental illness.
4	**Circumstances of the death.** Extensive evidence was taken and accepted by the court. In summary, of relevance to this report:

	On 21/12/2019 Ms Norman called the Single Point of Access (SPA) in a highly anxious state and informed the operative that she had had enough of life and felt like burden. Ms Norman then disconnected the call. There was no FU by SPA. On 31/12/2019, Ms Norman spoke to the Single Point of Access (SPA) and informed them that she had taken an overdose and cut her wrists in front of her son. No suicidality assessment nor clinical assessment was undertaken by the SPA operative that she spoke to and she was simply told to ring primary care mental health services, as she was already under their care. She was not put through to this service by SPA, nor were any concerns about her passed on by SPA to any other service, including no concerns being passed by SPA to her GP. Each of these calls were answered by administrators with no clinical qualifications. Evidence was taken in court from [redacted] the Service Manager representing SPA on these matters. Calls are apparently taken initially by non-clinical staff. They should call back if cut off as on 21/12/2019, and now "warm transfer" calls such as that of the 31/12/2019 to the service already providing care to the caller.
5	**Matters of Concern** 1. That SPA contacts are not routinely discussed with a supervising clinician, ss should have but did not happen in Ms Norman's case, where mental health symptoms and especially where suicidality is raised by the caller. 2. That such calls are not routinely passed on to a suitably qualified clinician able to undertake mental health assessment and assess risk for the patient. 3. That SPA contacts are not routinely notified to the patient's GP and any mental health services providing care for the patient.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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] [redacted] [redacted] Litigation Manager CNWL

	Cnw-tr.inquestscnwl@nhs.net [redacted] SPA Service Manager, CNWL 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	**14th March 2023.**  **Professor Fiona J Wilcox** **HM Senior Coroner Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED** **Inner West London Coroner's Court,** **33, Tachbrook Street,** **London.** **SW1V 2JR** **Telephone:0207 641 8789.**