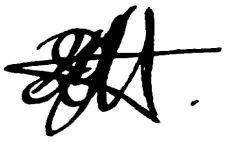
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted], Chief Executive Norfolk and Suffolk NHS Foundation Trust** **2 [redacted], CHIEF EXECUTIVE NHS ENGLAND**
1	**CORONER** I am Darren STEWART OBE, HM Area Coroner for the coroner area of Suffolk
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 03 August 2022 I commenced an investigation into the death of Ellen Ocean WOOLNOUGH aged 27. The investigation concluded at the end of the inquest on 13 February 2024. The conclusion of the inquest was that: Narrative Conclusion - Ellen Ocean WOOLNOUGH was described by her family and friends as a caring, compassionate, thoughtful, kind and generous person who exuded warmth and charisma. A person whose company was uplifting and who had a genuine desire to see the lives of those around her enhanced. Ellie had a history of mental health issues which started when she was around six years of age. Ellie had contact with mental health services between 2001 to 2011 following which her contact was sporadic up until 2022. Her mental health continued to suffer through her adolescence and into her young adult years. She was diagnosed with Emotionally Unstable Personality Disorder in April 2020. From 2019 Ellie's mental health problems became more acute when she suffered periods of physical illness, with particularly serious events identified in 2019 when she suffered from food poisoning and in May 2022 when she suffered from COVID. Although in May 2022 her physical symptoms were not severe, her mental health deteriorated significantly and she reported to her family that she attempted suicide by using a ligature on the 11th May 2022. She was seen the following day by the Crisis Resolution and Home Treatment Team (CRHTT) and following assessment referred to the Integrated Delivery Team (IDT). On the 20th May 2022 Ellie met with IDT staff for the purposes of an assessment, however this was curtailed when Ellie left the meeting abruptly. A further meeting was not attempted and Ellie was discharged from the IDT a few days later. On the 19th July 2022 Ellie had been suffering from a gastrointestinal illness for several days. Her family were concerned both in relation to her physical wellbeing but also her mental health which had deteriorated due to her physical health condition. Ellie's father contacted her GP who referred Ellie to the CRHTT as an urgent referral. Ellie was spoken to by the CRHTT on two occasions around 17:30 hours following which arrangements were made for Ellie to be seen the following day (20th July 2022) by the CRHTT at her home. Concerned about her physical condition, her family called an ambulance who attended late on the evening of 19th July 2022 and treated Ellie at home

	for dehydration. Following a period of time spent at her parents that evening, Ellie returned to her home in the early hours of the 20th July 2022 and went to bed. From around 06:41 am until 09:21 am Ellie exchanged a series of text messages and phone calls with her father and partner which caused increasing concern for her welfare and resulted in her father and partner attending her residence. On gaining entrance they discovered Ellie suspended by a ligature [redacted]. Ambulance attended and following attempts at resuscitation, a return of spontaneous circulation was achieved and Ellie was transported to hospital. Sadly she had suffered an irreversible hypoxic brain injury and despite treatment Ellie died on the 28th July 2022. Ellen Ocean WOOLNOUGH took her own life whilst suffering from the diagnosed mental health condition of emotionally unstable personality disorder. The medical cause of death was confirmed as: 1a Hypoxic Brain Injury 1b Hanging 1c
4	**CIRCUMSTANCES OF THE DEATH** Narrative Conclusion see Box 4.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) 1. The adequacy of Norfolk and Suffolk NHS Foundation Trust's (NSFT) Integrated Delivery Team (IDT) decision making concerning the discharge of a patient from mental health services in circumstances where a failed engagement has occurred. 2. The adequacy of NSFT's Crisis Rehabilitation Home Treatment Team (CRHTT) response to an urgent referral, in particular; risk assessment, safety planning and decision making concerning the downgrading of referrals. 3. Adequacy of the NHS England Patient Safety Incident Response Framework (PSIRF) to address serious incidents concerning patients and the implementation of this framework by NSFT. I received evidence from NSFT concerning the measures which that organisation had undertaken to address my concerns. This evidence included the following: a. Care Group communication has improved across the Trust. b. Skills Training on Risk Management (STORM), covering suicide and self-harm awareness training, was being implemented across the Trust. c. Staff were being engaged concerning waiting lists and expectation management and how to present these to patients in a positive manner. d. The downgrade policy concerning crisis line referrals had been changed in 2023 to make the circumstances concerning a downgrade clearer and what was expected of nursing staff involved in these decisions.

	This evidence has not allayed my concerns. I remain concerned that many of the measures outlined by NSFT are prospective and have not been introduced. I note: i. STORM training continues to be rolled out, although the evidence from a number of witnesses questioned the effectiveness of the rollout in reaching all staff. ii. Whilst the downgrade policy concerning urgent referrals has been tightened up, key parts of the process, such as the handover document between shifts, is still to be introduced. iii. The Trust SOP addressing the downgrading of urgent referrals, which I was told was revised in 2023, has not been provided to the Court and has not been implemented by the Trust. iv. Changes to the way the Trust investigates incidents such as Ellie's, including the use of a screening tool to determine how the PSIRF process is implemented, the requirement to retain recordings of calls and which statements are to be taken to inform serious patient incident investigations, are still to be introduced by the Trust. v. The failure by NSFT to preserve important evidence, in the form of recordings of calls between Ellie and the NSFT crisis call handler, at a time when it was on notice that this evidence would be important and relevant for the conduct of the Inquest, remains a concern.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by May 23, 2024. 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] I have also sent it to 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: 28/03/2024**  **Darren STEWART OBE** **HM Area Coroner for** **Suffolk**