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] **2** [redacted] **3 NSFT - Norfolk and Suffolk Foundation Trust (Legal Services)** **4 Chief Coroner's Office**
1	**CORONER** I am Nigel PARSLEY, HM Senior 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 22 May 2023 I commenced an investigation into the death of Owen Donal GARDNER aged 29. The investigation concluded at the end of the inquest on 03 July 2024. The conclusion of the inquest was that: Road Traffic Collision The medical cause of death was confirmed as: 1a Multiple Injuries 1b 1c
4	**CIRCUMSTANCES OF THE DEATH**
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) 5 CORONER'S CONCERNS During the course of the inquest the evidence revealed matters given 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 as follows. –

	In evidence it was heard that Owen had a limited short-term memory and a cognitive deficit, due to the previous Traumatic Brain Injuries that he had suffered. As a result of Owen's limited short-term memory and cognitive deficit, it was agreed that his next of kin would be informed of all of the appointments Owen had with the NSFT clinician's providing his care. Evidence at inquest heard that Owen's next of kin had been informed of such meetings on some occasions, but that it did not occur on every occasion. In addition, evidence was heard that when meetings were changed a short notice (due to unforeseen circumstances, staff sickness or leave absence), Owen himself would be informed, but not his agreed next of kin contact. This led to Owen missing a number of appointments as he had forgotten the changes made, whereas his next of kin would have been able to remind him, and prompt him to attend. It was acknowledged by the court, that in Owen's case there was no evidence that his attendance at one of his missed appointments would have changed the tragic outcome. However, I am concerned that in the future, an individual with a short-term memory and a cognitive deficit will miss an appointment which could prevent their death, if their next of kin (or chosen point of contact) are not also told of short notice changes to the timings of that appointment. Evidence was heard that there is no system in place to facilitate this.
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 September 09, 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 **NSFT - Norfolk and Suffolk Foundation Trust (Legal Services)** I have also sent it to [redacted] 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: 15/07/2024**  **Nigel PARSLEY** **HM Senior Coroner for** **Suffolk**