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:** **The Secretary of State for Health and Social Care:** [redacted] **The Department of Health and Social Care** **Email:** [redacted]
1	**CORONER** I am Jacqueline LAKE, Senior Coroner for the coroner 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 12 March 2024 I commenced an investigation into the death of Malcolm John TAYLOR aged 76. The investigation concluded at the end of the inquest on 25 October 2024. **The medical cause of death was:** 1a) Drowning 1b) 1c) 2) Ischemic Heart Disease, Cardiomegaly, Liver Fibrosis **The conclusion of the inquest was:** Suicide while suffering from extreme distress
4	**CIRCUMSTANCES OF THE DEATH** Mr Taylor was referred to Adult Social Services and Mental Health Team in December 2023. He was low in mood following the death of his wife. From February 2024 Mr Taylor's mood worsened and he remained under the care of the Mental Health Team. He was not taking his medication and had psychotic episodes and following assessment it was agreed consideration should be given to his being admitted to a mental health hospital. Mr Taylor expressed thoughts of self harm and suicidal intent. It was deemed appropriate not to carry out a formal Mental Act Assessment until a bed was available due to his paranoid presentation around professionals and concern his risk of self harm would increase. There was an urgent request for a bed to be found in a mental health hospital. On 3 March 2024 Mr Taylor drove to Gorleston [redacted]. He probably entered the sea at some time between 22.21 and 8 minutes after midnight on 4 March 2024. Mr Taylor was found on the shoreline at Gorleston beach on 4 March 2024. Mr Taylor died from drowning. A bed in a mental health hospital had not been found prior to Mr Taylor's 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) 1. Evidence was heard from NSFT as to action they have taken in an attempt to increase the number of beds available and so prevent future deaths, such as daily meetings of senior staff to discuss caseloads identified at high risk, prioritising those at high risk, weekly meetings with Directors and multi agencies to consider patient flow through the system and discussion with partner organisations to remove barriers to discharge to improve patient flow especially those with social care requirements. Despite these steps there remain insufficient beds available to meet patient need. At the time of Mr Taylor's death there were 13 patients awaiting beds. At the time of inquest, there were 7 patients awaiting beds. There are peaks and lows with these numbers on a daily basis but overall there remains a shortage of beds. 2. Evidence was heard this is a national problem and not limited to Norfolk and Suffolk NHS Trust.
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 December 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] - son Norfolk and Suffolk Foundation Trust 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 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 by the Chief Coroner.

9	**Dated: 28/10/2024** J Lake **Jacqueline LAKE** **Senior Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH