REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Norfolk and Suffolk NHS Foundation Trust (NSFT)** You are under a duty to respond to this report within 56 days of the date of this report, namely by 18th July 2026. I, the coroner, may extend the period if an appropriate application is made.
1	**CORONER** I am Daniel Sharpstone, Assistant 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 the 23rd March 2026 I resumed the Inquest into the death of Rebecca Jessie Mclellan (known as Becca) The conclusion of the Inquest on the 25th March 2026 was Suicide The Medical cause of death was given as: 1a) Hanging
4	**CIRCUMSTANCES OF THE DEATH** On 20th November 2023 Police forced entry into Becca's flat after concerns were raised by a colleague Becca was found hanging [redacted] Becca had left a final note and letters The Postmortem concluded that her death was due to hanging Becca was diagnosed with bipolar disorder in July 2022. She had been started on Aripiprazole but this was not tolerated Becca had an initial mental health assessment on the 26th October 2022 when she described pressure of speech and agitation with intermittent suicidal

	thoughts but no plans or intent She saw a Consultant Psychiatrist on the 22nd November 2022 and was started on Lamotrigine: she was in a mildly manic state A referral to the ADHD team was made in March 2023. Becca did not see the ADHD team before her death Becca had an urgent mental health review on the 23rd March 2023 as she was feeling flat At review on the 5th April 2023 Becca was flat in mood with a number of life stressors At her mental health assessment on 25th May 2023, Becca had made a concrete plan with a ligature and a piece of rope A further review took place on 30th May, noting Becca's mood had stabilised. Becca was functioning well and felt Lamotrigine [redacted]mg a day was helping her On the 7th August 2023 she presented in significant distress to the Trust. She had been without a dedicated care coordinator for approximately 9 weeks There was an urgent assessment with a Senior mental health care practitioner who then reviewed Becca formally on the 10th August 2023 There was a further mental health review on the 16th August 2023, with Becca complaining of low mood, life stressors and being unhappy about lack of follow-up due to the absence of her care co-ordinator Becca wasn't keen on increasing the dose of Lamotrigine due to side effects: fluoxetine was started with monitoring for hypomania On 14th September 2023 Becca said that the fluoxetine had improved her mood There was a plan to refer her to the eating disorders team in October 2023. Her BMI was 16.4 at that time. She didn't see the eating disorders team prior to her death In late October 2023, Becca developed Stevens-Johnson syndrome secondary to her Lamotrigine. The Lamotrigine was slowly reduced. She remained on Fluoxetine At her mental health assessment on 13th November 2023 Becca sounded flat in affect. She was anxious about starting Lithium as her Lamotrigine was being tailed off.
5	**CORONER'S CONCERNS** During the inquest the evidence revealed a matter giving rise to concern. In my

	opinion there is a risk that future deaths could occur unless action is taken. In these circumstances it is my statutory duty to report to you: **MATTER OF CONCERN** On the 31st May 2023, Becca's care co-ordinator in the Youth team went on planned, prolonged leave. On the 7th August 2023 Becca presented in significant distress to the Trust office that governed her mental health care. Due to issues with allocation, she had been without a dedicated, named care co-ordinator for approximately nine weeks. This was in part due to staff shortages. At that time, there were four vacancies out of the Youth team of sixteen. These were two Band 5, one Band 6 and a psychologist As a consequence of her distressed presentation at the Trust office, a senior mental health care practitioner urgently took over the role as Becca's care co-ordinator An update from the NSFT dated 2nd April 2026 described the current position with regards to vacancies as one Band 6 and one Assistant Psychologist in the Youth team. There is no documented system that I consider adequately highlights and manages planned, prolonged key care co-ordinator absence in the Youth team, nor a formal, documented process that clearly and accurately ensures that the roles and responsibilities of named key care co-ordinators are adequately covered during periods of planned leave. There is no process to ensure a dedicated, named care co-ordinator is identified to the mental health patient to provide continuity of care during prolonged periods of planned leave. I consider that the risk of a lack of a dedicated and identified care co-ordinator for a significant period during planned leave creates an ongoing risk of future deaths for people with significant mental health disorders, so consider this a matter for a PFD report.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths as detailed above, and I believe you or your organisation have the power to take any such action you identify.
7	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner.

	In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary
8	**COPIES and PUBLICATION** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1. [redacted] 2. 3. 4. I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to the top of the page above for additional information relating to the publication of reports and responses.
9	[redacted] **Daniel Sharpstone, HM Assistant Coroner for Suffolk.** **18th May 2026**