	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Inspector [redacted] Suffolk Constabulary Control Room** **2. [redacted] Legal Services Manager, Norfolk and Suffolk NHS Foundation Trust**
1	**CORONER** I am Dr Peter Dean, 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 28th of August 2012 I commenced an investigation into the death of Jamie Raymond Barlow, aged 29. The investigation concluded at the end of the inquest on the 25th of March 2014. The conclusion of the inquest was that Jamie Barlow took his own life.
4	**CIRCUMSTANCES OF THE DEATH** Jamie had been a patient of the Suffolk Early Intervention in Psychosis Service and had previously been discharged from the service having appeared to make progress and to have reasonable insight. The General Practitioner then contacted the service again having had an unusual phone call from Jamie in which he had claimed to have drunk bleach 10 days earlier (though whether this had, in fact, happened was questioned medically at the time and was not certain) and was expressing other comments that caused concern. There was not felt to be a need to see him as an emergency that day, but there were clearly communication problems about the plans that were then made for a subsequent assessment of Jamie. Jamie then failed to attend an appointment at the GP's surgery. The Mental Health Services were concerned about visiting him at his home, as there had been mention of him having weapons there, and police were not willing to conduct a welfare check without mental health personnel accompanying them as, based on the information they were given, they believed it might exacerbate the situation. Sadly, Jamie's body was found hanging some days later, in the area of his home but not easily visible.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – The significant extent of the post mortem changes to the body were such that it could not be established that a visit at the time requested would have avoided the tragic outcome in this particular instance but, although the inquest heard of some changes that had been made since the death, it was clear that there needed to be better inter-agency working, clarity when police assistance was sought in respect of exactly what they were being asked to do, a need to look at the processes operating here, and consideration of an inter-agency protocol for jointly managing the mental health assessment of patients who require such assessments but where there is a perception of risk to mental health professionals or members of the public.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 2nd of June 2014. 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 family. 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	**7-4-14** **Dr Peter Dean**