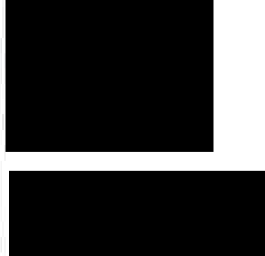
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Director of Community Services,** **Norfolk County Council,** **County Hall, Martineau Lane,** **Norwich** **NR1 2DH**
1	**CORONER** I am DAVID OSBORNE, Assistant 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 22 NOVEMBER 2013 an investigation was commenced into the death of SIMON TONY HAINES, 43YRS. The investigation concluded at the end of the inquest on 16 MAY 2014. The conclusion of the inquest was that Simon Haines killed himself, the medical cause of death being 1a Diphenhydramine Toxicity.
4	**CIRCUMSTANCES OF THE DEATH** On 21 November 2013 Simon Haines was found unresponsive in his parked vehicle by a member of the public. He was sadly declared deceased at the scene. Police were satisfied there were no suspicious circumstances or third party involvement. Evidence was heard regarding Simon Haines contact with Social Services in connection with a planned reuniting with his children. I heard from both the support worker to Simon Haines and the Social Worker assigned to the children. Although it had been planned for the children to return to live with their father, Simon Haines, I was told in evidence that ultimately both children stated they did not feel ready for this. Therefore the decision was taken for the children to remain in foster care. It was clear that this was a devastating outcome for Simon, and the Social Worker accepted this in her evidence to me. I was told by the support worker that Simon had indicated he did not want any further support. The Social Worker initially indicated that Simon was not at the time of the decision in May 2013 signposted to support (e.g. well being service and/or GP) if he felt he was struggling. On further questioning she indicated that he had been, but appeared not to wish to follow this up. The content of emails sent by Simon to the Social Worker in August 2013, which the Social Worker stated she did not see until October due to firstly a month's leave and then pressure of work, showed that Simon was still having difficulty with what had happened. He was not further signposted as it was considered that this had already been done in May and there was no need.

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. – On the evidence I received, as outlined above, it was unclear whether there was any protocol or guidelines for signposting someone in Simon Haines' position who might be having difficulty accepting a decision or outcome, and little or no consideration was given to re-signposting. I am concerned therefore that, without a review of the current system, whilst it can not be said whether the outcome for Simon would have been different, there is a continuing risk that others might not be signposted to other agencies and services for help and support in similar circumstances, and that if they were this would or might prevent future incidents similar to Simon Haines'.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your department 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 17 July 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 following Interested Persons:  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	**22 May 2014**