IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of George Nigel Palmer
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: CMHRS
1	**CORONER** Martin Fleming Assistant Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009 paragraph 7, schedule 5 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 11/4/14 I opened the inquest into the death of George Nigel Palmer, who at the date his death was 20 years old. The inquest was resumed and concluded on 11/9/14. I found that the cause of death to be: 1a – Hanging I concluded with a narrative conclusion as follows: George Nigel Palmer died by his own hand whilst suffering from anxiety and depression.
4	**CIRCUMSTANCES OF THE DEATH** On 7/4/14 George Nigel Palmer was found to have died at his home address. He ws suspended from a belt attached to his bedroom door. He had a previous history of depression and anxiety and because of concerns of self harm, he was admitted to the Priory Hospital as an inpatient between 16th-29th/1/14, where he was diagnosed as suffering with a major depressive illness, for which he was prescribed medication. Upon his discharge he was referred to the Crisis Team and CMHRS and was seen at his home address on 11/2/14 when his mental state was thought to have improved, and upon 20/2/14 when he was assessed as looking forward to starting at Durham University. Because of his

	perceived improvement in his mental health, and his movement to Durham, he was discharged from the CMHRS. Although George agreed to provide the contact details of his GP in Durham he did not forward them in order to facilitate possible further mental health support.
5	**CORONER'S CONCERNS** During the inquest [redacted] Registered Mental Health Nurse, provided helpful evidence and the following concerns were highlighted: - • Discharge follow up mechanisms to contact patients who transfer to a different area to ensure that they are offered continuity of support. • Appropriateness of follow up letters to the patient in the event of non-contact. I would ask that you consider giving further consideration to the above to ensure that there is no further repetition.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the CMHRS has the power to take action
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** • [redacted] • [redacted] – GP • [redacted] – Consultant Psychiatrist • Chief Coroner
9	**Signed: Martin Fleming – Assistant Coroner for Surrey** **DATED this 15th September 2015**