REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive, Kent and Medway NHS and Social Care Partnership Trust** **Chief Executive, Care Quality Commission;** **Secretary of State, Department of Health**
1	**CORONER** I am Rebecca Margaret COBB, Senior Coroner for the Coroner area of North East Kent
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 25th July 2013 I commenced an investigation into the death of Joshua Lewis BROWN. The investigation concluded at the end of the inquest on 8th May 2014. The conclusion of the inquest was: "Took his own life whilst suffering from depression", the clinical cause of death being: 1a) Multiple injuries
4	**CIRCUMSTANCES OF THE DEATH** Mr Brown died on 13th June 2011 at the foot of cliffs at Louisa Bay, Broadstairs, Kent having been recorded on the CCTV of a nearby property to climb over the railings at the cliff edge, stand on the other side for about a minute then put his arms out to the side and drop forward off the cliff. Prior to that he had sat for around 15 minutes on a nearby bench. He had a history of self-harm and had had many suicidal thoughts and had also verbally on occasions that year indicated his intention to take his own life. He had been diagnosed as suffering from moderate depression on a background of maladaptive personality traits and was under the care of the Community Health Team ("the Team").
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:- (1) The evidence was that Mr Brown lived with his parents who were therefore his primary support outside the Community Health Team but were not strictly speaking his carers and therefore were not formally able to be involved as such by the Community Team when Mr Brown did not wish information about him to be shared. They therefore did not receive information that might have alerted

	them to periods when he was particularly vulnerable and when they might have had information that would have been of assistance to the Team in caring for Mr Brown. (2) The evidence also demonstrated that it was not the practice of the Team to show family members what notes had been made by the Team of information shared with them by family members, with the consequence that inaccuracies or misunderstandings may have arisen in some notes, and there was no provision for those notes to be signed as accurate by the relevant family members. (3) The family members were not made aware of ways in which they could obtain through the Kent and Medway NHS Social Care and Partnership Trust (of which the Team was a part) more information about how they might best support Mr Brown and themselves receive support. (4) In general, the evidence showed limitations on the possibilities for engagement by the Team with family members and by family members with the Team, particularly when Mr Brown did not wish information about him to be shared and this worked to his disadvantage. There was, however, evidence of some improvement having already been made by the Trust in this respect. When engagement was possible, the absence of a system whereby a person giving information to the Team would check that that information had been correctly noted and interpreted by the Team posed obvious risks for anyone under the care of the Team.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe you and your organisation are in a position 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 11th September 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 the following Interested Persons: [redacted] and [redacted] 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	**17th July 2014** **Alan J Blunsdon** **Senior Coroner – North East Kent Area** **For and on behalf of Miss Rebecca Cobb**