Robin J. Balmain
H.M. SENIOR CORONER

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BLACK COUNTRY CORONER'S DISTRICT
(SANDWELL • DUDLEY • WALSALL • WOLVERHAMPTON
Metropolitan Borough Councils)

Date: Date 3rd July 2014 Our Ref: RJB Your Ref:

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO :

Clinical Governance Facilitator
Dudley & Walsall NHS Mental Health
Partnership NHS Trust
Clinical Governance Dept., 76 Ida Road
Walsall WS2 9SS

Re: Nadine Gillian THURMAN deceased

1. CORONER

I Robin John Balmain am the Senior Coroner for the Black Country Coroners Jurisdiction

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

This investigation was commenced on 12th November 2012 and concluded on 23rd June 2014. A conclusion was reached that the deceased hung herself whilst suffering from an anxiety related disorder.

4. CIRCUMSTANCES OF THE DEATH

There was a history of paracetamol and vodka misuse on 19th October 2012 following treatment she was seen by the crisis team. On 28th October 2012 there was a further misuse of paracetamol and hospital treatment and again seen by the crisis team. On 5th November 2012 Mrs. Thurman was found hanging at home.

5. CORONERS CONCERNS

The **MATTERS OF CONCERN** are as follows :-

My concerns relate to the psychiatric assessment of Mrs. Thurman. [redacted] gave evidence to me that he was not allowed to contribute to the assessment. I was told that Mrs. Thurman was asked by a nurse if she was content to be seen on her own. That seems to me to be an approach that is suggestive of the answer and is

likely to exclude relevant information. It seems to me that the approach to someone being assessed should be along the lines *"Are you happy for your family to be involved in and make a contribution to the assessment"*. I was also told by a hospital nurse that on contacting the crisis team to ask if a relative could be present, the crisis team always refuse.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you 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 the report, namely by **28th August 2014.**

8. COPIES and PUBLICATIONS

I have sent a copy of my report to the Chief Coroner and [redacted] the husband.

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.

R.J. Balmain
Senior Coroner
BAP