REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive** **Norfolk & Suffolk NHS Foundation Trust** **Trust Headquarters** **Hellesdon Hospital** **Drayton High Road** **Norwich** **NR6 5BE**
1.	**CORONER** I am JACQUELINE LAKE, Senior 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 31 October 2014 I commenced an investigation into the death of THOMAS THEO CHARLES THURLING, age 36. The investigation concluded at the end of the inquest on 28 July 2015. The conclusion of the inquest was medical cause of death: 1a) Asphyxiation and CONCLUSION: Mr Thurling took his own life. His intention at the time is not known.
4	**CIRCUMSTANCES OF THE DEATH** Mr Thurling was showing increasing signs of depression and anxiety. A member of Mind went to see him on 27 October 2014 at his home but there was no response. On 28 October 2014 another member of Mind went to his home. On receiving no response Police were called and entry gained to his home. Mr Thurling was found clearly dead.
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) On 13 August 2014 Mr Thurling's medication was changed to help his low mood and anxiety. The Psychiatrist specifically stated that the change in medication was to be monitored to include the involvement of the CRHT Team. One Psychiatrist gave evidence (which was read) that the change in medication was closely monitored by Mind. Mr Thurling later declined any input from the CRHT Team. His Care Co-Ordinator was unaware of the symptoms to look for. Despite close involvement, Mr Thurling's family were unaware of the change in medication and the request for monitoring. Although Mr Thurling was seen daily by Mind they were unaware of any change in medication and the request for monitoring. An Out Patient Review was not arranged until 6 weeks later. Following that Out Patient Review the Care Co-Ordinator was absent from work on planned and unplanned leave. Nothing was put in place to monitor the medication.

	(2) Care Co-ordinator was on planned and unplanned leave from end September 2014 until time of Mr Thurling's death. Her Line Managers were aware of this continuous absence. Prior to this there had been a general deterioration in Mr Thurling's mental health noted, he was clearly expressing suicidal ideation, He had attended A & E with thoughts of suicide and he had bought a penknife and cut his neck. His mother had contacted MH Team expressing her concerns on at least 2 occasions. The Care Co-Ordinator had recommended a Nurse be appointed. Mr Thurling had a known fear of being abandoned by his family and MH Services. Mr Thurling was not reviewed during this period. No alternative Care Co-Ordinator was appointed. (3) It is clear from evidence given at the inquest that there is a shortage of staff at the Trust. Steps are being taken to try and address this but it is unclear as to what is being done in the meantime to cope with the difficulties that arise as a result.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 5 October 2015 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: [redacted] (parents) 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	**6 August 2015** [redacted]