REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Practice Manager** **Norwich Practices Health Centre** **(formerly Timber Hill Health Centre)** **Rouen House** **Rouen Road** **Norwich** **NR1 1RB**
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 5 February 2015, I commenced an investigation into the death of SOLOMON JAMES BEALEY, AGE 15 YEARS. The investigation concluded at the end of the inquest on 30 September 2015. The conclusion of the inquest was Medical Cause of Death: 1a) Self Asphyxiation; Conclusion: Suicide.
4	**CIRCUMSTANCES OF THE DEATH** Solomon had some previous contact with Mental Health Services. In 2010 Solomon attempted to hang himself. Solomon's contact with Children's Services ceased in 2012. He presented with some problems with school work and he indicated on one occasion he was drinking alcohol. Solomon was self-harming and posting photographs of himself with a noose on the internet which was not known to parents or teachers. Solomon was found in his bedroom with a bag over his head and a cord round his neck on the morning of 5 February 2015. He left a note to all his family telling them he loved them and thanking them.
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) Solomon was taken to see a Nurse at the Walk In Clinic on 1 October 2014 for minor medical matters. The Nurse became concerned at signs of stress and was aware that in 2010 Solomon was found preparing to hang himself, and so arranged for an on call Doctor to see him. No action was taken. The Nurse expressed her concerns to a GP in the practice. A telephone call was made to a number believed to be that of the mother of Solomon, but it was a wrong number. The Doctor wrote to Solomon's mother on two occasions and received no reply. The matter was not pursued any further.

	(2) Although the letters had been received by Solomon's mother who discussed this with Solomon and his father and it was decided to take no further action, the Doctor was unaware that the letters had been received. (3) No follow up action was taken.
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 3 December 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] (mother) [redacted] (father) LOCAL SAFEGUARDING BOARD. I have also sent it to Care Quality Commission who may find it useful or of interest. 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	**8 October 2015** ..... **Jaqueline Lake** **Senior Coroner for Norfolk**