REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Director of Community Services – Adult Social Care** **Norfolk County Council** **County Hall** **Martineau Lane** **Norwich** **NR1 2DH**
1	**CORONER** I am DAVID OSBORNE, Assistant 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 27 March 2015, an investigation was commenced into the death of LORRAINE SHEILA YOUNGS aged 35 years. The investigation concluded at the end of the inquest on 27 January 2016. The conclusion of the inquest which was held before a jury was that she killed herself by a deliberate act but it is unclear if she intended to kill herself. The medical cause of death was 1a: Hanging.
4	**CIRCUMSTANCES OF THE DEATH** At the time of her death Lorraine Young's was a detained patient at Hellesdon Hospital. She was discovered on 24 March 2015, unresponsive in the public pay phone room on the ward having wrapped the telephone cord around her neck. A pulse was regained but she sadly died at Norfolk and Norwich Hospital 2 days later.
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. – The inquest heard evidence regarding Lorraine Young's care in the community. Evidence was given from Lorraine's social worker that a care package had been agreed in principle at a visit on 12 February 2015. At the time of her death, this had not been implemented. The evidence given was that this had not been followed up. Whilst it could not be said in the context of Lorraine's death whether the delay affected the outcome, I was concerned that a delay in following up implementation of an agreed care package could, in different circumstances, affect the outcome for a vulnerable Service User. The evidence before the inquest was that there appeared to be no system for following up implementation of an agreed care package.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation 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 this report, namely by 28 March 2016. 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 have also sent it to The Department of Health The CQC Norfolk County Council - Democratic Services Healthwatch Norfolk 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	**1 February 2016** ..... **David Osborne** **Assistant Coroner for Norfolk**