ANNEX A

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:** **North Essex Partnership University NHS Foundation Trust**
1	**CORONER** I am Mrs Caroline Beasley-Murray, HM SENIOR Coroner, for the area of Essex
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 15 March 2016, I reopened the inquest touching upon the death of Dorota Agnieszka Kijowska. I sat with a jury and on 17 March the jury recorded the following conclusions:- *On 23 March 2015, at approximately 16.10pm Dorota Agnieszka Kijowska was found hanging by a scarf from an unsecured loft hatch in a toilet cubicle at Gosfield ward the Lakes Colchester. Resuscitation attempts were unsuccessful and she was pronounced dead at 17.10pm.* *Dorota Agnieszka Kijowska killed herself.* *Based on the evidence provided, the jury have concluded that there was a failure to provide a safe environment at the unit and this, in conjunction with ineffective communication, more than minimally contributed to her death.*
4	**CIRCUMSTANCES OF THE DEATH** **Please see jury's findings above.** She had been an informal patient at the Lakes Mental Health Unit from 10 March 2015 and she returned from weekend leave at 8am on Monday 23 March 2015. At a review held that day, Dorota expressed threats to harm herself and the plan to give her a further period of home leave appears to have been changed. This was not relayed effectively to Dorota who was found hanging later in the afternoon.
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 outcome of the review meeting was not signed off in writing by those in attendance (Consultant psychiatrist, middle grade doctor, review nurse) and clearly communicated to Dorota

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation have the power to take such action. Such important decisions must be agreed by all those present and signed off in writing so that there is no confusion as to the outcome of the review.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 23rd May 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. Family solicitors, Gotelee
9	**Mrs Caroline Beasley-Murray** **29 March 2016**