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:** **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 3 June 2014 I commenced an investigation into the death of JO ANNE CAROL NOBBS, AGED 36 years. The investigation concluded at the end of the inquest on 3 December 2014. The conclusion of the inquest was Medical Cause of Death: Unascertained. Short Form Conclusion: Open.
4	**CIRCUMSTANCES OF THE DEATH** Miss Nobbs had long standing physical problems and mental health issues. She was diagnosed in 2009 with Borderline Personality Disorder. She did not always engage with professionals. From January 2014 her GP and sister noted deterioration in her mental health. In February 2014 she began to disengage from the various professionals, although continued to self refer to hospital for a variety of physical symptoms. The Community Mental Health Team tried contacting her on a number of occasions from March up to the date of her death with no success. She stopped collecting her medications on 8 May 2014. Her GP and the Pharmacy called Police to carry out a welfare check on 30 May 2014. Police found her dead in her home on 2 June 2014.
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) A correlation between Miss Nobbs' deteriorating physical health and her deteriorating mental health was noted by some mental health professionals and documented in her mental health records but this was not investigated or acted upon by other mental health professionals, despite Miss Nobbs attending at A & E Department, Norfolk & Norwich University Hospital on at least 10 occasions between January and March 2014 presenting with a variety of symptoms and at varying times of day and night (2) A Care Plan was put in place in January 2014 of steps to be taken on the basis that Miss Nobbs was going to engage with mental health services. The evidence is that this plan was kept under review and was a "continuing" plan. There is no documentation supporting such a continuing plan, particularly when Miss Nobbs was no longer engaging with mental health services. She had not been seen on a 1:1 basis since before 26th February 2014 by any of the Community Mental Health Team, save in respect of a believed sighting in the street. There is no evidence of a revised Care Plan being put in place, save in respect of continuing to try to make contact with Miss Nobbs.
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 29 January 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] (sister) 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	**4 December 2014** ..... **Jacqueline Lake** **Senior Coroner for Norfolk**