Kally Cheema LLB
HM Senior Coroner for County of Cumbria

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: [redacted], Cumbria, Northumberland, Tyne and Wear NHS Trust**
1	**CORONER** I am Dr Nicholas Shaw Assistant Coroner for **County of Cumbria**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 16/10/2018 I commenced an investigation into the death of Charlotte Grace. The investigation concluded at the end of the inquest 29th October 2019. The conclusion of the inquest was Charlotte (Lottie) Grace suffered from a complex personality disorder, she had a long history of suicidal ideation and had made two previous suicide attempts. Despite intensive support from mental health services and her friends she took her life by hanging at East Curthwaite, Cumbria on 21st September 2018. Hanging.
4	**CIRCUMSTANCES OF THE DEATH** **Lottie was discharged from Yewdale Ward, West Cumberland Hospital on the afternoon of 20th September 2018, the following evening, having been missing all day she was found hanging in a barn near the cottage where she lived alone. At inquest evidence was given that Lottie was at chronic high risk of suicide, and that while she had requested her nominated next of kin be present at discharge meeting they were not invited, neither was the Home Treatment Team to whom she had been referred for follow up care. It was acknowledged that discharge rather than continued in patient stay was a better option therapeutically and that there were no grounds for detention under the mental health act.**
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) Lottie was discharged despite there being no input from those to whose care she was being entrusted. 2 years ago I sat on an inquest in Carlisle which found that a gentleman hanged himself 2 days after a discharge from the Carleton Clinic when again the Home Treatment Team were expected to take over but not invited to the discharge meeting. I understand this is now less likely to occur in Carlisle and would be generally desirable. I am concerned that agencies to whom a patient is discharged and families or friends [with consent] who will need to be supportive are not routinely involved in the discharge process.

	(2)---------- (3)----------

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your NHS Trust 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 27th December 2019. 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 Person [redacted] [nominated by Lottie as next-of-kin] 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	29/10/2019 Dr Nicholas Shaw Assistant Coroner **County of Cumbria**