Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1. **Chief Executive**
   Norfolk & Suffolk NHS Foundation Trust
   Hellesdon Hospital
   Drayton High Road
   Hellesdon
   Norwich NR6 5BE

1. CORONER

I am Jacqueline LAKE, Senior Coroner for the 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 17/08/2020 I commenced an investigation into the death of Mary Jane BUSH aged 15. The investigation concluded at the end of the inquest on 19/10/2021. The medical cause of death was:

1a) [redacted]
1b)
1c)
2

The conclusion of the inquest was: Suicide.

4. CIRCUMSTANCES OF THE DEATH

Mary Bush had a diagnosis of anxiety disorder, post-traumatic stress syndrome and suicidal ideation. She was referred to the mental health team in November 2019 and was assessed in January 2020. Mary Bush was awaiting referral for psychological therapy at the time of her death. On 6 August 2020 Mary was found [redacted] to her home. Evidence was heard that Mary had intended to take her own life by her actions

5. CORONER'S CONCERNS

During the course of the inquest, the evidence revealed matters giving rise to concern. I was satisfied after hearing evidence that action has been taken to address many of those concerns. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances, it is my statutory duty to report to you.

The outstanding matters of concern are as follows:

1. Mary was referred to the mental health team in November 2019 and was assessed in January 2020, some three weeks later than should have been.
2. There was a delay in Mary receiving psychological therapy. She was still on the waiting list at the time of her death.
3. The evidence was that at the date of inquest, there continued to be a delay in service users receiving psychological therapy. Evidence was heard that balancing capacity and demand, which has increased, remains a challenge. The cases referred are of increasing complexity, as in Mary's case
4. Some steps have been taken in an effort to deal with this, such as specific risk assessment training, focusing on intervention treatment plans to aid capacity and throughput, reviewing the skill mix of staff
5. However, there is the ongoing issue of recruitment and retention of suitably skilled staff by the Trust and the ability to resource this to enable the Trust to function effectively

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 14 December 2021. 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]

I have also sent it to:

1. NHS Norfolk & Waveney Clinical Commissioning Group, Lakeside 400, Old Chapel Way, Broadland Business Park, Thorpe St Andrew, Norwich NR7 0WG
2. Secretary of State for Health & Social Care, Ministerial Correspondence and Public Enquiries Unit, Department of Health and Social Care, 39 Victoria Street, London SW1H 0EU
3. Child Death Overview Panel, County Hall, Martineau Lane, Norwich NR1 2DH
4. Local Safeguarding Board, County Hall, Martineau Lane, Norwich NR1 2DH
5. [redacted] on behalf of the Coroner's Society for England & Wales

who may find it useful or of interest.

I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

I may also send a copy of your response to any other person who I believe may find it useful or of interest.

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.

9. Dated: 20 October 2021

Jacqueline LAKE
Senior Coroner for Norfolk
Norfolk Coroner Service
County Hall
Martineau Lane
Norwich NR1 2DH