


REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>Professor Jonathan Warren Chief Executive Norfolk & Suffolk NHS Foundation Trust 1st Floor Admin, Hellesdon Hospital Drayton High Road Hellesdon Norwich NR6 5BE</p>
1	<p>CORONER</p> <p>I am YVONNE BLAKE, area coroner, for the coroner area of NORFOLK</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 7 June 2019 I commenced an investigation into the death of Peter Frosdick aged 48 years. The investigation concluded at the end of the inquest on 28 November 2019. The conclusion of the inquest was cause of death 1a) Hanging and that whilst Mr Frosdick took his own life, he was unable to form the necessary intent due to his state of mind.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Mr Frosdick chronically abused alcohol. In 2018 he had blood tests and then a CT scan which showed cirrhosis of the liver. He was advised that he should stop drinking alcohol. He became convinced that he was going to die of liver failure. This was not the case. Had he been told this 6 months earlier he would have been able to stop drinking and be saved. This was an irrational view as he was not in liver failure. He was referred to the Mental Health Team/Crisis Resolution/Wellbeing, none of which accepted him for treatment as it was felt that his major problem was alcohol misuse. He was displaying paranoid thinking, was showing extreme anxiety and irrational behaviour. He hung himself in his garage.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>During 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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>(1) That no-one appeared to have looked at his mental health except to note that he was alcohol dependant. This was an escalating presentation from someone who had no previous contact with the services.</p>

	<p>(2) His mental state was not classed as a psychiatric illness and since he did not fit neatly under a label he was not taken on. When seen by the Crisis Home Resolution Treatment Team, home treatment was not offered or explored. His mother states that hospital admission was not offered and a referral to Wellbeing Services should have been made but wasn't.</p> <p>(3) The various teams within the Trust seem to be unaware of each other's referral criteria and displayed little or no professional curiosity and appeared to dismiss his GP's opinion which gave a clear description of his worsening presentation and the fact that he had been abstinent from alcohol.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by February 6, 2020. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:-</p> <p>██████████ (mother) ██████████ (GP)</p> <p>who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>12 December 2019</p> <p style="text-align: center;">  [SIGNED BY CORONER] Norfolk Coroner Service Carrow House 301 King Street Norwich NR1 2TN </p>