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:** **1. The Chief Executive,** **Lancashire Care NHS Foundation Trust**
1	**CORONER** I am Alan Wilson, Senior Coroner, for the area of Blackpool & Fylde
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 6th July 2010 an investigation commenced into the death of Roy Frank Fletcher, aged 63 years. The investigation concluded at the end of the inquest heard on 12th and 19th December 2013. The record of the inquest confirmed as follows: The Medical cause of death was Ia Hanging The conclusion of the Coroner as to the death was Narrative conclusion as follows: **Roy Frank Fletcher had a long history of depression. On the 25th May 2010 he was admitted to the Conway Ward, and acute admission ward, at Parkwood Hospital in Blackpool. He was agreeable to remaining there for care and treatment.** **Following an incident of self harm during a period of unescorted leave, a decision was taken that he could only be allowed escorted leave.** **At a Care Programme Approach Review on 6th July 2010 Roy handed to his therapeutic team some hand written notes within which he had sought to explain how he was feeling. Before the content of those notes had been fully considered he decided to leave Parkwood. Later that day he exited the Conway Ward through a door that had been left partially open. He made his way to the main exit from the building. When another service user was allowed to leave the reception area Roy took the opportunity to follow that service user out of the building. It was not appreciated that Roy had no**

	permission to leave at that time. **Roy made his way to a local holiday park and at approximately 7.30 pm was found deceased having taken his own life by hanging himself by use of a rope as a ligature whilst the balance of his mind was disturbed.**
4	**CIRCUMSTANCES OF THE DEATH** See the contents of section 3 above.
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. – At the conclusion of the inquest, I indicated to the Properly Interested Persons that I proposed to write to the Trust by way of a report in accordance with the provisions of paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009. During the Inquiry, I received written evidence by way of a post incident review conducted by the Trust into the death of the Deceased. On 19th December 2013 I received oral evidence from [redacted] on behalf of the Trust and who was the author of the Post Incident Review. I am concerned that the review undertaken was significantly lacking for the following reasons: • CCTV footage shows that at the relevant time the Deceased shows him following another Service User out of the reception area at the hospital. It seems no steps had been taken to speak to that Service User in order to establish if he had been aware that he was a vehicle for the Deceased's exit from hospital, and if so on what basis. • Further, the oral evidence provided to the inquiry by [redacted] suggested that the review had not explored whether other service users had left the relevant ward, or the reception area of the hospital in similar circumstances. Having concluded this inquest, I now write to the Trust to confirm that in my view the Trust should take action because: • When Post Incident Reviews are undertaken it is important that they are thorough and comprehensive and that all of the relevant issues are explored prior to recommendations being made arising from that review and the organisation making recommendation for remedial action, if any, to be undertaken. • If such reviews are lacking, there is a risk that an organisation may not appreciate whether a problem is a persistent one, potentially helpful changes to procedures may not be put in place and future deaths may occur which may otherwise have been prevented. I would therefore be obliged if the Trust would write to me in due course to confirm what steps if any the Trust proposes to take to address these concerns.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have 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 17th February 2014. 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 The family of Roy Frank Fletcher The Coroners Society 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	**Alan Wilson** **Senior Coroner for the area of Blackpool & Fylde** **Dated: 20th December 2013**