**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**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>1. Mr Simon Barber, Chief Executive, 5 Boroughs Partnership NHS Foundation Trust, Hollins Park House, Hollins Lane, Winwick, Warrington, WA2 8WA. |
|---|---|
| 1 | **CORONER**<br><br>I am Alan Peter Walsh, Area Coroner for the Coroner Area of Manchester West |
| | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 10th July 2013 I commenced an investigation into the death of Howard Simon Sankey otherwise known at Howard Simon Gee, Aged 29 years, born on the 12th December 1984.<br><br>The investigation concluded at the end of the Inquest on the 12th December 2013.<br><br>The medical cause of death was 1a) Suspension by Ligature.<br><br>The conclusion of the Inquest was Howard Simon Sankey took his own life. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>The deceased had a volatile relationship with [redacted] with whom he had previously resided at [redacted], Leigh and they had a son, [redacted] born in 2012.<br><br>The deceased was separated from [redacted] who continued to reside at [redacted] Leigh, and in July 2013 he was residing with his mother at [redacted] Leigh.<br><br>On the 4th July 2013 the deceased had stayed overnight at [redacted], Leigh and at or about 14:15 hours on that day he was found, having died, suspended by a ligature attached to a ceiling metal support in the garage at the address leaving a note indicating his intention to end his life.<br><br>On the 1st July 2013 the deceased had attended his General Practitioner, Dr |

at the Dr Alistair Partnership, Atherton with a fear that he had bi - polar disorder and he described a long history of erratic mood swings and impulsive behaviour. Dr referred the deceased to the Gateway and Advice Service, Leigh which is also known as the Wigan Assessment Service (hereinafter referred to as Gateway) based at Claire House Health Centre, Phoenix Way, Lower Ince, Wigan. Dr used a form headed "Gateway and Advice Service, Leigh Screening and Referral Form" to submit the form by fax. In completing the form Dr made some mistakes, including the deceased's previous name of Howard Gee and the wrong address, but the contact telephone numbers on the form were correct. The contact telephone numbers referred to the deceased's and his mother's mobile telephone numbers. In the risk factors section of the Form Dr stated "no home, living with mother as a temporary measure. Please contact patient today via his mother's mobile phone." The Form was sent to Gateway by Dr by fax on the 2nd July 2013 at 08.35 hours.

Gateway is part of 5 Boroughs Partnership NHS Foundation Trust and is based at Claire House Health Centre, Phoenix Way, Lower Ince, Wigan. It is a single point of access into secondary mental health services providing specialist mental health assessment, advice and signposting for adults suspected to be suffering from moderate to severe mental health problems.

Gateway has four categories of urgency namely :-

1. Accident and Emergency Department - to be seen immediately.
2. Emergency – appointment will be offered within a maximum of 24 hours of the referral.
3. Urgent – an appointment will be offered within a maximum of 72 hours of the referral.
4. Routine – an appointment will be offered within 10 days of the referral.

The categorisation of a referral is done by an Administration Assistant with no training or experience of risk assessment and the Assistant prepares the referrals into hard copy files which are placed in piles relating to each category for a Senior Nurse Practitioner to contact the service user. There is no sifting procedure by the Senior Nurse Practitioner to prioritise individual cases within each category and there is no immediate check or review of the categorisation following the decision made by the Administration Assistant.

At the time of the referral relating to the deceased there was only one Senior Nurse Practitioner on duty at any one time although on occasions there may have an additional member of staff on duty in the team dealing with referrals. Notwithstanding the fact that Dr requested contact "today" the deceased was categorised as a Routine referral and handed to the Senior Nurse Practitioner as a Routine referral.

The procedure in relation to handling a referral is referred to in written Operational Guidance, which provides that after receipt by Gateway, the referral should be logged on to the OTTER system (Electronic Patient Record Computer System) by the Administration Assistant stating the priority deemed by the referrer, the priority allocated by the screening practitioner and the clinical rationale for the allocated response time. The referral should be passed

to the Senior Nurse Practitioner within 30 minutes of it being logged on to the system and the Senior Practitioner should review the information and/or carry out a telephone screening with the referrer or individual referred in order to make a reasonable assumption about the level of service priority. The evidence at the Inquest was that the above procedure was not followed by Senior Nurse Practitioners in relation to the deceased or any other referred cases.

In relation to the deceased the referral was entered on to the OTTER system at 10.00 hours on the 2$^{nd}$ July 2013 and the referral was allocated to the Senior Nurse Practitioner at 10.10 hours on the same date. The referral was not reviewed by the Senior Nurse Practitioner and there was no attempt to carry out a telephone screening with the referrer or the deceased until 19.36 hours on the 2$^{nd}$ July 2013. The OTTER system showed that the Senior Nurse Practitioner acknowledged the referral at 19.34 hours and telephoned the deceased using the deceased mobile telephone number at 19.36 hours. The Senior Nurse Practitioner did not follow the instruction on the referral form to contact the deceased via his mother's mobile phone, which was correctly stated on the referral form. There was no reply from the deceased's mobile telephone but the Senior Nurse Practitioner did not make any further telephone calls either to the referrer or the mother's mobile telephone and no further contact was attempted by Gateway until the deceased himself telephoned Gateway at 16.00 hours on the 3$^{rd}$ July 2013.

When the deceased telephoned Gateway at 16.00 hours on the 3$^{rd}$ July 2013 he spoke to a Senior Nurse Practitioner who reassessed his case as an Urgent case and he was given an appointment to attend Claire House Health Centre to see a Senior Nurse Practitioner on the 5$^{th}$ July 2013 at 11.30 hours. The evidence at the Inquest indicated that the deceased had been offered an appointment on the 4$^{th}$ July 2013 but the deceased wanted to speak to his mother prior to the appointment and he agreed the appointment on the 5$^{th}$ July 2013.

In the meantime the deceased died on the 4$^{th}$ July 2013 prior to the allocated appointment.

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) During the Inquest evidence was heard that :-

i) The categorisation and allocation as between Emergency, Urgent and Routine referrals is done by an Administration Assistant who is not qualified nor trained to carry out such duties. The Administration Assistant enters the service user on to the OTTER system with the category of urgency and the hard copy file is delivered to the Senior Nurse Practitioner including details of the referral which should be acknowledged by the Senior Nurse Practitioner within 30 minutes of receipt.

ii) There is no review of the hard copy file, the referral form or the entry on the electronic patient record to enable a review of the category of urgency assessed by the Administration Assistant. Furthermore there is no action taken by the Senior Nurse Practitioner to prioritise referrals within each category to identify the more urgent cases within each category to ensure contact with the service user within the most appropriate time for that service user.

iii) The OTTER system provides a list of all referrals in date and time order identifying the category of urgency but the list is not available to each Senior Nurse Practitioner and the list is only available to the Manager of the team.

iv) At the time of the referral relating to the deceased only one Senior Nurse Practitioner was on duty at any one time dealing with all referrals. The Gateway Team has 16 members who are engaged in different duties and many of the duties are out of the office. The Senior Nurse Practitioner on duty deals with all written or faxed referrals, including Emergency, Urgent and Routine referrals together with all telephone referrals and other request to Gateway either by telephone or by personal attendance. There are 500 to 600 recorded referrals to Gateway each month so that there are 25 to 30 referrals each working day.
Evidence was given at the Inquest that a new team has been established at the Hospital to deal with referrals through the Accident and Emergency Department at the Hospital and an additional member of staff now works with the Senior Nurse Practitioner in relation to other referrals but there is still a very high and unpredictable workload for the Senior Nurse Practitioner each day.

v) When a service user is not contacted or when an attempt to contact has failed the hard copy file is put into a file tray to be picked up whenever by another Senior Nurse Practitioner. There is no system of reviewing the none contact referrals within an appropriate and reasonable time. There is a handover from one Senior Nurse Practitioner to another Senior Nurse Practitioner at the end of each shift and there is a meeting each morning to discuss outstanding cases but there is no system to ensure that all outstanding cases are considered at the morning meeting and there is no re-prioritisation of the cases to ensure that all service users are contacted within an appropriate and reasonable period. In the case of the deceased his referral was not discussed at the morning meeting on the 3rd July 2013 after contact had failed at 19.36 the previous evening and his referral had not been reviewed by any Practitioner prior to his telephone call at 16.00 hours on the 3rd July 2013.

vi) The evidence at the Inquest revealed in effective management of the Team to co-ordinate and allocate resources to deal with an

unpredictable number of referrals each day. The list of referrals in date and time order prepared by the computer system is only accessible to the Team Manager who did not appear to share the information on the list with Senior Nurse Practitioners to ensure that any delays in contact with a service user would be actioned and reviewed taking account of the date and time of the referral.

2. I have concerns with regard to the 5 Boroughs Partnership NHS Foundation Trust, particularly the Gateway Team, in relation to:

   i) The categorisation and allocation of referrals by an Administration Assistant who has insufficient knowledge and who is not trained to make such important decisions

   ii) The prioritisation of each referral to ensure contact within an appropriate and reasonable period of time having regard to the urgency and merits of each referral.

   iii) The system to ensure contact with service users within appropriate time periods particularly when the initial contact with the service user has failed.

   iv) The systems and procedures to ensure contact with service users within appropriate time periods following receipt of the referral and the fact that the computerised list of referrals in date and time order is not available to Senior Nurse Practitioners.

   v) The ineffectiveness of handovers as between Senior Nurse Practitioners and the ineffectiveness of the morning meetings to review referrals particularly those referrals where the initial contact with the service user has failed.

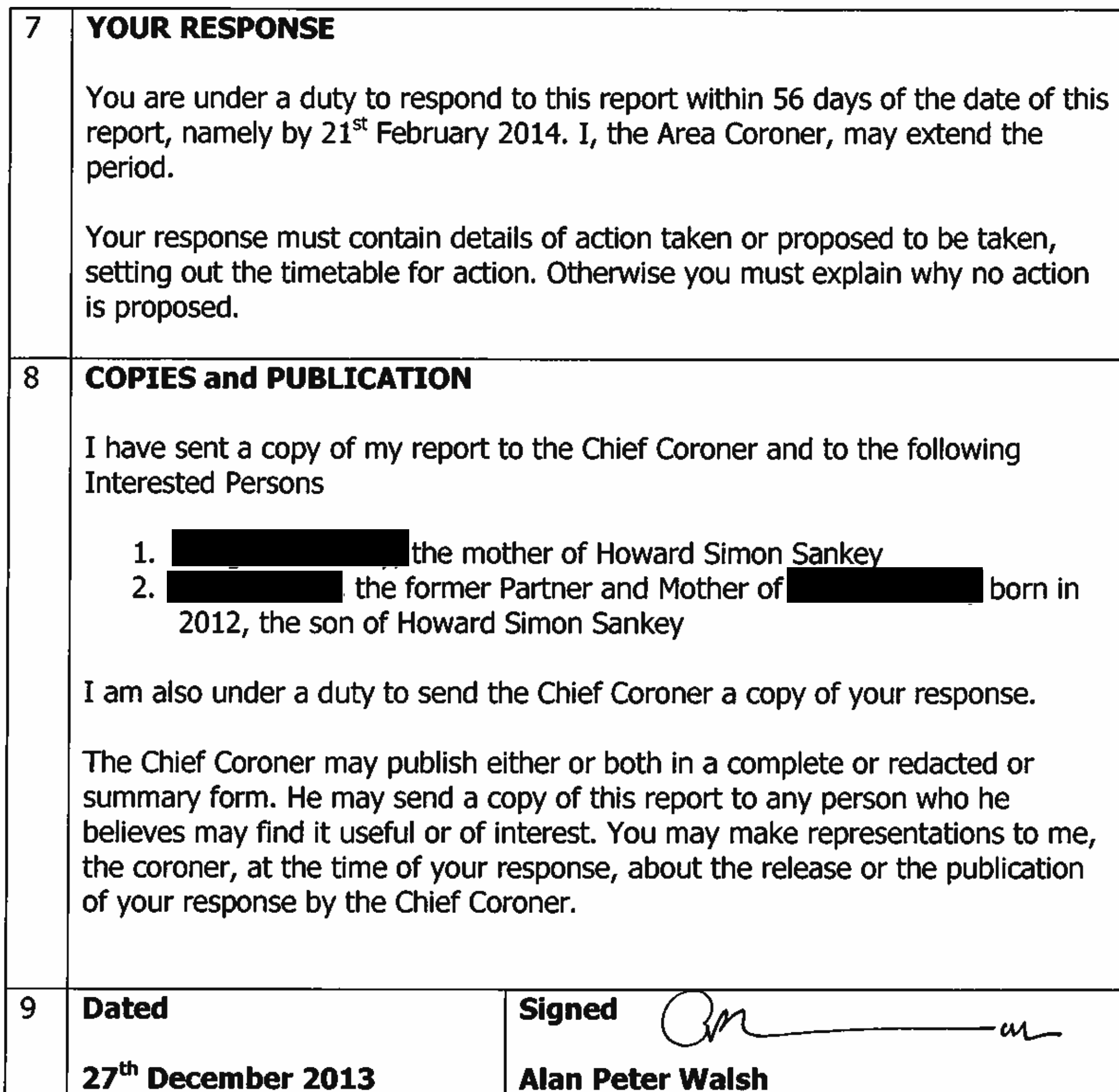
   vi) The staffing levels on each shift, particularly having regard to a large and unpredictable volume of referrals each day.

   vii) The ineffective management of the team as a whole and in particular Senior Nurse Practitioners to co-ordinate and allocate resources to deal with the large volume of referrals within the appropriate time period.

   viii) The training of staff in relation to the written Operational Guidance, which was not followed by any of the Senior Nurse Practitioners who gave evidence at the Inquest, to ensure that referrals are dealt with and service users are seen within appropriate time periods.

6 **ACTION SHOULD BE TAKEN**

In my opinion urgent 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 21st February 2014. I, the Area 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

1. [redacted] the mother of Howard Simon Sankey
2. [redacted] the former Partner and Mother of [redacted] born in 2012, the son of Howard Simon Sankey

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 | **Dated** | **Signed** |
|---|---|---|
| | **27th December 2013** | **Alan Peter Walsh** |