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.** Mr Simon Barber, Chief Executive, 5 Boroughs Partnership, NHS Foundation Trust, Hollins Park House, Winwick, WA2 9WA.
1	**CORONER** I am Mr Alan Peter Walsh, HM Area Coroner, for the Coroner Area of Manchester West
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 26th November 2014 I commenced an investigation into the death of Magdalen Bernadette Dwerryhouse, 77 years, born 14th April 1946. The investigation concluded at the end of the inquest on 16th May 2014. The medical cause of death was: 1a) Inhalation of Products of Combustion 2) Coronary Artery Atheroma The conclusion of the inquest was Misadventure.
4	**CIRCUMSTANCES OF THE DEATH** 1. Magdalen Bernadette Dwerryhouse died at her home address [redacted] Bradley Lane, Standish, Wigan on the 25th November 2013. 2. The deceased lived alone at 223 Bradley Lane, Standish, Wigan with the support of her daughter [redacted] who lives in France and her Grandson [redacted] who lives nearby. 3. In July 2013 the deceased developed loss of appetite and weight which was investigated and in November 2013 she developed evidence of a paranoid mental illness which was being assessed at the time of her death. 4. On the 1st November 2013 [redacted], who was the deceased's General Practitioner, was contacted by [redacted] and she expressed concern about her Mother's mental state. [redacted] visited

the deceased on the same day and she saw the deceased in the presence of [redacted] conducted an assessment which identified two issues namely auditory hallucinations and possible delusions. [redacted] also recorded that there was no evidence of depression but there was a previous history of the deceased failing to answer telephone calls from her phone.

5. [redacted] referred the deceased to 5 Boroughs Partnership NHS Foundation Trust for mental health assessment and the referral was received by the trust on the 4th November 2013.

6. On the 6th November 2013 [redacted] who is a registered Psychiatric Nurse and a Senior Nurse Practitioner with 5 Boroughs Partnership NHS Foundation Trust, attended the deceased's home address and conducted a mental health assessment. [redacted] arranged the assessment with [redacted], who was present, to allow [redacted] access to the premises and to assist with information in relation to the assessment.

   The mental health assessment was arranged with [redacted] in view of the fact that the referral form completed by [redacted] and submitted to 5 Boroughs Partnership NHS Foundation Trust stated "Will not answer the telephone" and gave contact telephone numbers for [redacted] and [redacted].

7. Following the assessment the deceased was discussed at a multi-disciplinary team meeting at 5 Boroughs Partnership NHS Foundation Trust on the 7th November 2013 and the meeting decided that the deceased should be reviewed by an Occupational Therapist and a Consultant Psychiatrist. The review was arranged for the 15th November 2013 and the review was to take place at the deceased's home address. Notice of the review and the visit of the Occupational Therapist and Consultant Psychiatrist was sent to the deceased by letter and no arrangements were made by contacting either [redacted] or [redacted] in accordance with the previous contact arrangements.

8. On the 15th November [redacted] a Consultant Psychiatrist and [redacted] acting Deputy Manager for the Wigan and Leigh Mental Health Assessment Team, being part of the 5 Boroughs Partnership NHS Foundation Trust, visited the deceased's home address without any arrangement to meet [redacted] at the address as before. The deceased did not respond to attempts to gain entry to the premises by [redacted] and [redacted] who left the premises without making any telephone contact with either [redacted] or [redacted] No contact was made with office of 5 Boroughs Partnership NHS Foundation Trust on the 15th November 2013 and there was no contact with [redacted] who has made the initial referral to the Trust. A note was placed on the record of 5 Boroughs Partnership NHS Foundation Trust on the 18th November 2013, which noted the failed visit to the deceased's home address, and on the 21st November 2013 [redacted] telephoned the Trust to be

	informed that the visit had failed and [redacted] suggested contact with the family. No contact was made with the family and evidence was given at the inquest that a letter was to be sent to the deceased on the 26th November 2013 to rearrange the visit but the letter was not sent. 9. On the 25th November 2013 the deceased was found at her home address, which had been damaged by fire originating in the kitchen of the premises together with smoke damage arising from the fire. The deceased was found in a collapsed and unresponsive condition at the bottom of the stairs in the premises and she was diagnosed as having died at the premises on that date. 10. It was accepted at the inquest that the deceased was a vulnerable person but there had been no contact with any outside agencies including the Greater Manchester Fire and Rescue Service with regard to her vulnerability or to arrange further assessments to protect her, particularly in relation to fire.
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 referral of the deceased to 5 Boroughs Partnership NHS Foundation Trust by [redacted] on the 4th November 2013 was appropriate and gained an appropriate response from the Trust by the initial assessment on the 6th November 2013. The initial assessment was arranged by contacting the family telephone numbers given by [redacted] on the letter of referral to the Trust but the subsequent appointment on the 15th November 2013 was not made in the same way and did not involve the family as requested by [redacted] ii. When [redacted] attended the premises on the 15th November 2013 and failed to gain access they made no contact with a member of the family, nor [redacted] and they did not appear to take account of the information recorded on the initial referral letter submitted by [redacted] They did not make contact with the Trust's office on that date and subsequently there was no contact with the family and no attempt to rearrange the appointment, other than the indication of a letter 11 days later which was not sent. Furthermore there was no contact with the family following the telephone call by [redacted] on the 21st November 2013.

iii. Greater Manchester Fire and Rescue Service provide home safety checks free of charge to persons at an increased risk of fire and the Fire Service has developed a register of individuals who are at an increased risk of fire. Had information regarding the deceased's condition been referred to the Fire Service she would have been included on this register and prioritised for home safety checks. The Fire Service continues to develop and utilise referral pathways with other agencies in the form of partnership agreements to ensure that individuals at increased risk of fire are identified at the earliest opportunity and relevant fire prevention interventions are implemented. The Fire Service recommends that Clinical Commissioning Groups, Mental Health Trusts and other health providers develop agreements regarding the sharing and use of information that would enable the delivery of more cost effective support and potentially improve outcomes for those most at risk.

The Greater Manchester Fire and Rescue Service has attempted over the last 2 years to develop a partnership with 5 Boroughs Partnership NHS Foundation Trust but evidence was given by the Fire Service that attempts at a partnership had been thwarted and delayed and there appeared to be a lack of continuity of staff involved in discussions and a lack of motivation on the part of the Trust to enter into a partnership. The Fire Service identifies individuals with mental health and behavioural problems as vulnerable individuals at high risk and, whilst it has been difficult to form a partnership with 5 Boroughs Partnership NHS Foundation Trust, the Fire Service does have partnerships with other Mental Health Trusts within the area covered by the Greater Manchester Fire and Rescue Service.

The Fire Service would have been prepared to attend the multi-disciplinary team meeting held at the 5 Boroughs Partnership NHS Foundation Trust on the 7th November 2013 to assist in assessment and any action to be taken in relation to the deceased but there was no contact with the Fire Service, who was not invited to attend.

2. I have concerns with regard to the following:-

i. The systems and procedures within 5 Boroughs Partnership NHS Foundation Trust with regard to the arrangements of appointments with vulnerable individuals particularly when directions are given by a Health Professional, namely [redacted] in the case of the deceased.

ii. I have further concerns with regard to procedures to be undertaken if a visit fails for lack of access including contact with family and the original referrer to rearrange an

	appointment as soon as possible. iii. The absence of any partnership agreement between the Greater Manchester Fire Service and 5 Boroughs NHS Foundation Trust which has failed to develop over the last two years and which is essential to allow the Fire Service to take action to prevent future deaths. 3. I request you to consider the above concerns and to review the following:- i. The arrangements of appointments, contact with members of the family and the procedures in relation to failed home visits with a view to immediate action to contact family members and original referrers to alert them to the failed visits and to establish the reason for the failed visit and to rearrange the visit as soon as possible. ii. The formation of a partnership with the Greater Manchester Fire and Rescue Service.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and 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 24th July 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:- 1. [redacted], Daughter of the deceased 2. [redacted] Grandson of the deceased 3. Chief Fire Officer, Greater Manchester Fire and Rescue Service 4. [redacted] Dempster, Community Safety Manager, Greater Manchester Fire and Rescue Service 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** **29th May 2014**	**Signed**  **Mr Alan P Walsh**