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.** Chief Executive of Lancashire Care NHS Foundation Trust, Sceptre Point, Sceptre Way, Walton Summit, Preston, PR5 6AW
1	**CORONER** I am Rachael Clare Griffin Assistant 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 the 13th October 2014 I commenced an investigation into the death of Robert Paul Yarnell, born on the 22nd March 1964. The investigation concluded at the end of the inquest on the 6th February 2015. The Medical Cause of Death was 1a Multiple Injuries. The conclusion of the inquest was that Robert Paul Yarnell took his own life whilst suffering from depression.
4	**CIRCUMSTANCES OF THE DEATH** Robert Paul Yarnell was diagnosed as suffering with depression in October 2010. At around 1pm on the 8th October 2014 Mr Yarnell drove his motor vehicle to Barton Bridge on the M60 Motorway in Greater Manchester, and was seen to alight from the vehicle, climb over the railings of the bridge and jump from the bridge to the floor below, causing injuries that resulted in his death.
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. On the 3rd July 2014 Mr Yarnell was admitted to the Darwen Ward of the Pendleview Inpatient Mental Health Unit at the Royal Blackburn Hospital, under Section 2 of the Mental Health Act 1983 for assessment as a result of a deterioration in his mental health. During this admission Mr Yarnell was diagnosed with unspecified non-organic psychosis.

   ii. Following the expiry of the assessment period, Mr Yarnell was discharged from the Unit on the 31st July 2014 with a need for continuing care to be given by the Burnley and Pendle Complex Care and Treatment Team of the Lancashire Care NHS Foundation Trust, whose role it is to support adults with severe and enduring mental illness in the community. Mr Yarnell was allocated a care coordinator and continuing care was to be provided to him in the community.

   iii. Prior to his hospital admission Mr Yarnell had been residing at his home address in Nelson, Lancashire, however upon his discharge arrangements were made for him to initially reside at his mother's address in Urmston, Greater Manchester with a view to him returning to his home address to live with his wife, in Nelson in due course.

   iv. Following his discharge on the 31st July 2014 the Burnley and Pendle Complex Care and Treatment Team contacted Mr Yarnell by telephone on the 1st August 2014. As Mr Yarnell had relocated to the Greater Manchester area, the Burnley and Pendle Complex Care and Treatment Team made a referral to the Trafford Crisis Resolution Home Treatment Team for them to take over Mr Yarnell's continuing care.

   v. Trafford Crisis Resolution Home Treatment Team completed their assessment of Mr Yarnell on the 2nd August 2014 and reported to the Burnley and Pendle Complex Care and Treatment Team on the 4th August 2014, that Mr Yarnell did not require their support and they would not be providing any further care or treatment for him.

   vi. At this time therefore, the care of Mr Yarnell remained with Burnley and Pendle Complex Care and Treatment Team and attempts were made by them to contact Mr Yarnell. Telephone calls were made to Mr Yarnell's mother's address on the 4th August 2014, 11th August 2014 and the 27th August 2014, however on each occasion no contact was made with Mr Yarnell. A letter was sent to Mr Yarnell's mother's address on 27th August 2014 requesting he make contact. No visits were made to his address nor was any attempt made to contact other members of his family such as his wife or sister, who had been actively

	involved in Mr Yarnell's care and whose details were known to those who had treated Mr Yarnell previously prior to his discharge from hospital on the 31st July 2014. vii. Mr Yarnell made contact with the Burnley and Pendle Complex Care and Treatment Team on the 15th September 2014, which was over six weeks after his last contact with them on the 1st August 2014. Following this contact Mr Yarnell did engage with the Burnley and Pendle Complex Care and Treatment Team. viii. The evidence at the inquest was that problems can occur when a service user who requires continuing treatment, moves out of the area, as due to that move they are may not be provided with the continuing treatment they need. The evidence given was that the protocols regarding the transfer of a service user out of the area provided by Lancashire Care NHS Foundation Trust are not clear, and that the Burnley and Pendle Complex Care and Treatment Team can be left with risky situations to manage. 2. I have concerns with regard to the following: i. Due to Mr Yarnell moving out of the area there was a significant delay in the continuing care that he received following his discharge from hospital after a section 2 admission under the Mental Health Act 1983. Although Mr Yarnell did contact the services of his own volition some time later, I have concerns that in future cases a service user who requires ongoing support and treatment from Lancashire Care NHS Foundation Trust, may not receive it due to residing outside the Trust area. ii. The procedures and protocols currently in place within Lancashire Care NHS Foundation Trust for the continuing care of a service user, when that service user moves out of the area, are not clear and give rise to risky and potentially fatal situations.
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, 10th April 2015. 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) Mr Yarnell's wife, [redacted] (2) Mr Yarnell's sister, [redacted] 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** **13th February 2015**	**Signed** [redacted] **Rachael C Griffin**