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 **RE: Alice Anne McMeekin Deceased** **THIS REPORT IS BEING SENT TO:** **1. Mr Jerry Graham, Chief Constable, Cumbria Constabulary** **2. [redacted] Cumbria Partnership NHS Foundation Trust (CPFT)**
1	**CORONER** I am David Llewelyn Roberts, Senior Coroner for the coroner area of Cumbria.
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 19th day of June 2013, I commenced an investigation into the death of Alice Anne McMeekin – 58 years of age. The investigation concluded at the end of the inquest on 22nd May 2015. The conclusion of the inquest Cause of death: 1a) Head Injuries Conclusion: Unlawfully killed
4	**CIRCUMSTANCES OF THE DEATH** At About 8.00hrs on the 8th June 2013 at Newton Street, Millom, Cumbria, the deceased was attacked by a male living at that address. He struck her repeatedly about the head with a hatchet as a result of which she sustained fatal head injuries. Two days prior to this incident the perpetrator had attempted suicide and had been taken to hospital. There he was assessed as at zero risk to himself or others. On the balance of probability the perpetrator was suffered from a recognised mental disorder at the time of the attack.
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.The Police The evidence revealed that on the 6th June 2013 the perpetrator made remarks to a member of the public to the effect that he "would not kill his mother". This information was passed to the Officers who attended the area. Some 2 hours later the same officers attended a call about a man behaving strangely and covered in blood. An ambulance was called. The officers had not spoken to the original caller, who subsequently gave evidence that the remarks were that the perpetrator said he "would kill his mother". "Common sense" told the officers that the person was one and the same and they did a welfare check on his mother.

	At no stage did they question the perpetrator about his originally reported remarks. Also, citing confidentially they did not pass those remarks onto the Ambulance Team. This meant that when later seen by the psychiatric nurse the latter was in ignorance of this significant statement. It is possible that had the nurse been aware this may have altered the outcome of the perpetrator's initial assessment and how he was dealt with. 2.The Partnership Trust The Coroner concluded that the evidence at the inquest showed that the perpetrator was suffering from a mental disorder when he tried to kill himself on the 6th June 2013. Whilst the psychiatric nurse that day did not have all the information which was available at the inquest he had information to show that perpetrator had a history of self-harm, unemployment, family stressors, multiple and complex drug misuse, quasi-incestuous sexual feelings, past sex abuse, hopelessness, low mood and serious suicide attempt that day. 3.Not withstanding the above the nurse decided that the perpetrator was of zero risk and was not suffering from a mental disorder. He was discharged with the only potential follow up being talking therapy which would not commence, if it ever did, some weeks hence. The evidence at inquest shows that this was a very disturbed young man having intended to kill himself 6 hours earlier and who remained a risk to himself. Whilst on the information known to the nurse at the time the tragic outcome could not have been anticipated, there was an opportunity to render care, which could, as a consequence have made a difference. It is a concern that the two assessments after the killings also concluded the perpetrator was not suffering from a mental disorder.
6	**ACTION SHOULD BE TAKEN** 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. **Chief Constable** (1)To examine the mechanism of passing information to other agencies – in particular the ambulance service or mental health service so that issues of confidentiality do not impede the protection of life. (2)To review the forensic psychiatric services available to the police. **CPFT** (1) To examine its system of first contact assessment in respect of unknown patients presenting in crisis. (2) What steps might be taken to guard against low frequency, high impact events. (3) To review single nurse assessment in such circumstances and the risk assessment tools used in such processes.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Friday 31st July 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: 

	And also the following:- Prof. [redacted] and the Chair of the Homicide Review 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	**4th June 2015 Signed** [redacted] **David Roberts HM Senior Coroner**