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:** **Chief Executive, Lancashire Care NHS Foundation Trust** **Sceptre Point** **Sceptre Way** **Walton Summit** **Preston** **PR5 6AW**
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 11 February 2015 I opened an inquest into the death of **Piotr Grzegorz Kucharz** aged 37 years. The inquest concluded on 19th November 2015. The conclusion of the Coroner as to the death was a narrative conclusion as follows: Piotr Kucharz took his own life after the risk of him doing so was not fully recognised. The medical cause of death was: 1 (a) Cerebral Hypoxia 1 (b) Ligature Strangulation .
4	**CIRCUMSTANCES OF THE DEATH** Box 3 of the Record of Inquest recorded as follows: Piotr Kucharz, previously diagnosed as suffering from, schizophrenia, was admitted to a mental health hospital during the evening of Friday 3 October 2014.

	Having last been seen alive at 1605 hours on Wednesday 8 October 2014, and after subsequent and planned checks on his welfare did not take place, he was found unresponsive and lying on the floor of his room at approximately 17.15 hours having used a cord as a ligature to strangle himself. He was taken to hospital, where despite treatment he passed away at approximately 2200 hours on 12 October 2014. The absence of an effective translation service to assist with his limited understanding of English, and a decision made on 7 October 2014 to reduce the frequency of checks made on his welfare contributed to his decision to end his life.
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. Piotr Kucharz was a Polish gentleman who commenced living in the United Kingdom in April 2014. At the time he sought to strangle himself with a cord he was an informal patient at the Conway Ward at Parkwood, a mental health facility in Blackpool. At his inquest, evidence was heard from a number of members of staff as regards what constitutes an effective observation. He was the subject of what were described as Safety and Security [SAS] and general observations the completion of which was the responsibility of a number of members of care staff. The evidence heard from staff raised an area of concern because that evidence indicated quite clearly that there was a lack of consistency and clarity as regards what constitutes an effective observation. An independent expert witness indicated in a report that he completed prior to the inquest that he felt custom and practice was such that some staff were merely checking on the "whereabouts" of the patient. Some staff felt that they were expected to enter the room of the patient and to try to engage with him and to check the room environment for anything that may pose a risk to him. Others felt that whether they were expected to actually enter a patient's room to conduct the observation could vary depending on the level of risk a particular patient presented, in other words that they felt they had an element of discretion as regards whether they entered the room. This evidence appeared to be in contrast to a Trust policy. In the case of Piotr Kucharz, as can be seen above he had limited understanding of English, and a number of staff gave evidence that he remained in his room throughout his time on the Conway Ward and did not wish to engage with them. Nevertheless, the author of the Trust's Sudden Untoward Incident Review document agreed that there was no such discretion and that staff ought to enter the room to complete and effective observation. At the conclusion to the inquest I expressed the view that I was concerned that there is a risk of future deaths because staff remain unclear about what amounts to an effective observation, and more specifically whether there are circumstances which may allow them to refrain from verbally engaging with a patient, or from physically entering a patient's room to check the environment, and that should that lack of consistency and clarity prevail, other patients may be placed at risk as a result of inadequate observations.

	For the avoidance of doubt, I confirm that I am of the opinion that the above concern remains valid despite the fact that further to Piotr Kucharz's death the provision of mental health care for patient's such as Piotr has moved from the Conway Ward at Parkwood to another facility within my jurisdiction at which members of staff who were working at the time of Piotr's death continue to be employed in a similar capacity.
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 19th January 2016. 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 Piotr Grzegorz Kucharz The Priory Hospital, Altrincham, Cheshire The University Hospital of South Manchester The Manchester Mental Health & Social Care Trust [redacted] [Consultant Psychiatrist at The Priory Hospital] 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	A.A. Wilson **Alan Wilson** **Senior Coroner for Blackpool & The Fylde** **Dated: 24th November 2015**