REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive, 5 Boroughs Partnership NHS Foundation Trust, Hollins Park House, Hollins Lane, Winwick, Warrington, WA2 8WA**
1	**CORONER** I am Nicholas Rheinberg senior coroner, for the coroner area of Cheshire
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 20th July 2016 an investigation was commenced into the death of David Moran aged 49. The investigation concluded at the end of the inquest on 4th January 2017. The conclusion of the inquest was that the deceased who died as a result of a metformin overdose took a fatal overdose of his medication but that his intention in doing so could not be determined.
4	**CIRCUMSTANCES OF THE DEATH** The deceased who suffered from bi-polar affective disorder had a history which included suicide attempt and suicidal ideation. During a period of relapse he was contacted by a nurse from the Trust's Warrington Assessment Team following a notification of concern from the deceased's brother. The nurse attempted to complete the Trust's screening tool without success. Trust Guidance set three levels of priority in dealing with referrals depending upon whether the need to see and assess the patient could be categorised as an emergency, as urgent or as routine. The nurse assessed the referral as routine. Subsequent to the nurse's conversation with the deceased, his brother telephoned your service on not less than two subsequent occasions voicing increased concerns for the deceased but the calls were neither logged by the administrator who will have taken the call or entered within medical records with the result that an increasingly urgent need for assessment was not identified.
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 Trust Guidance for categorising the urgency of a referral appeared imprecise. Further, in that the referral system will often depend on a telephone conversation only, there did not appear to be a default to urgent in a case where a screening assessment was not possible or in a case of doubt or ambiguity. (2) Communication between administrative staff and nursing / clinical staff did not appear to be effective.

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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 6th March 2017. 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 Person, Jeffrey Moran on behalf of the deceased's family and the CQC.. 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	**6th January 2017** **Nicholas, Leslie, Rheinberg** **Senior Coroner**