ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Heather Thierney-Moore, Chief Executive, Lancashire Care Foundation Trust**
1	**CORONER** I am Miss Claire Hammond, Area Coroner, for the coroner area of Preston and West Lancashire.
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 26 May 2015 I commenced an investigation into the death of Stephen McDermott, 32 years of age. The investigation concluded at the end of an inquest on 2 March 2017, after hearing evidence on 1 and 2 March 2017. The medical cause of death was 1a hanging and my conclusion at the end of the inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** Stephen McDermott was found deceased by his mother on 25 May 2015 at his home address where he had died sometime earlier as a result of the intentional application of a ligature. Of relevance to the Regulation 28 Report is that over a four-month period prior to his death Mr McDermott had presented at Accident and Emergency at Chorley and South Ribble District and General Hospital on three occasions (16.2.15, 23.3.15, 6.4.15), having overdosed on drugs and alcohol and twice having been recovered from the train tracks. On each occasion he was assessed by a member of the mental health liaison team from Lancashire Care Foundation Trust ['LCFT'] and discharged without any follow-up from mental heath services, the view being taken that the issue was one of substance misuse and that there was no immediate suicide risk. In addition, on 16 March 2015, Mr McDermott's General Practitioner contacted the Single Point of Access Team ['SPOA'] by telephone to request a mental health assessment, so concerned was he about Mr McDermott's deteriorating state of mind. Again, no referral was made for follow-up with mental health services, the view being taken that the issue was one of substance misuse (the inquest found that there was no assessment of suicide risk during that telephone call). Further, on 1 April 2015 Mr McDermott's mother contacted the SPOA to advise that in her view Mr McDermott was in crisis, at risk of suicide and had written a suicide note. Although a face-to-face appointment was organised for him in 8 days' time, it was subsequently cancelled, and when Mr McDermott attended for it he was turned away

without being seen.

The inquest heard independent expert evidence from [redacted] consultant psychiatrist, who made a number of criticisms of the level of care provided to Mr McDermott by LCFT and of the record keeping systems in place, staff training and the standard of the Trust's 'Team Incident Review.' She was of the view, and the senior trust witnesses accepted [redacted] (consultant psychiatrist and leader author of the Team Incident Review) and [redacted] Service Manager for adult mental health services), that there had been missed opportunities to attempt to facilitate treatment.

Although I did not conclude that these issues caused or contributed to the death, it is my opinion that their existence means there is a risk that future deaths will occur unless action is taken.

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 electronic record system is not the same across all mental health teams (Single Point of Access, Crisis Team, Mindsmatter) meaning that not all relevant records were available at each point of assessment of Mr McDermott – Mindsmatter use 'IAPTS' and the other teams use 'ECR Blue' as opposed to there being one record system for all to use and to ensure mental health records are in one place. Although [redacted] gave evidence that Mindsmatter now has access to ECR Blue and the other teams have access to IAPTS, his evidence was that the system remains "clunky." His evidence was that a new electronic system has been commissioned, but he did not know whether it was one system for all teams to have access to and/or whether the problems highlighted in this case would remain. In addition, the system is not due to be implemented for a further 18 months. He agreed that having one electronic system used by all teams would be of benefit;

2) In addition to the problems highlighted above of not having all records on one system, there was evidence of poor use of the records that were available resulting in liaison nurses who were assessing Mr McDermott having an incomplete picture:
   a) During the GP's telephone call to [redacted] at the Single Point of Access team on 16 March 2015, [redacted] did not check the full records to learn the background of Mr McDermott's recent admission following an overdose;
   b) During her assessment of Mr McDermott on 27 March 2015, [redacted] mental health liaison nurse, was only aware that Mr McDermott had taken an overdose of drugs and alcohol. She was unaware that Mr McDermott had been brought to Accident and Emergency whilst intoxicated having been located near the train station by police and having reported to them that he was having thoughts of jumping in front of a train, a fact that was readily available in the records;
   c) Following his assessment of Mr McDermott on 6 April 2015, [redacted] mental health liaison nurse, discharged Mr McDermott without a plan for referral into the crisis team for assessment. Part of his rationale for this was that Mr McDermott told him he had an appointment with

Mindsmatter on 9 April. This was incorrect (this date was in fact due to the be the first face-to-face appointment with the SPOA, which was subsequently cancelled) and demonstrates that [redacted] either did not have access to or did not properly check relevant records;

3) There was evidence of poor training with regards to incomplete assessments and poor record keeping. In respect of the telephone call from the GP to [redacted] at the SPOA on 16 March 2015, there is no evidence in the records to evidence that [redacted] asked any questions regarding Mr McDermott's mental health, despite the fact that the GP was requesting referral into services for a mental health assessment. There is no evidence that [redacted] followed the 'Storm' guidance (guidance that had not been disclosed at the inquest) to assess suicide risk factors or mental health issues. His evidence was that he would have asked the relevant questions but just did not document the responses, but I found on the balance of probabilities that the questions had not been asked;

4) Following on from the above, of particular concern was that [redacted] line manager, [redacted] (the Access and Treatment Team Deputy Manager) said in evidence that negative answers to questions would not necessarily always be documented. [redacted], the independent expert, [redacted] and [redacted] all agreed that the records should always be a complete picture with recording of negative answers being an essential part of that;

5) Mr McDermott's problems were repeatedly treated as substance misuse issues without any consideration or assessment of whether mental health issues might be the underlying cause of the substance misuse issues. Individuals assessing Mr McDermott repeatedly had their views clouded by substance misuse issues, which prevented Mr McDermott from being referred into mental health services for assessment. Although the Trust's 'Team Incident Review' ['TIR'] identified that a "more flexible approach" was required in relation to overlapping substance misuse and mental health issues, there was no evidence at the inquest that trust policies or procedures have changed in this respect, nor any evidence of staff being trained to approach such cases differently;

6) Following a telephone call made to the SPOA by Mr McDermott's mother on 1 April 2015, in which she advised that she feared he was at risk of suicide and had written a suicide note, contact was made with Mr McDermott who confirmed he could keep himself safe so an appointment was made for him to have a face-to-face assessment at the SPOA on 9 April 2015. However, this appointment was cancelled by the SPOA team on 7 April because Mr McDermott had been assessed by [redacted] on 6 April following his attendance at Accident and Emergency. The SPOA considered that to assess him on 9 April would be a duplication. The expert's view, with which [redacted] agreed, was that this was a missed opportunity to have a face-to-face assessment of Mr McDermott in a non-crisis situation;

7) It was apparent that when patients are assessed and treated by other services, in this case Discover Drug and Alcohol Recovery Services provided by Greater Manchester West NHS Foundation Trust ['GMW'], LCFT do not have access to GMW records and vice versa. In a case such as this, where there is a significant overlap between mental health issues and substance misuse issues, it is of significant concern that services do not / cannot share information to assist in their assessment processes to ensure that they are in possession of the full

	picture of an individual's presentation; 8) Although LCFT instigated a 'Team Incident Review,' the inquest found that it was incomplete in some important respects, most notably in that it made no reference whatsoever to the telephone call from the GP to [redacted] on 16 March 2015, an incident which I found was the real trigger point at which Mr McDermott ought to have been referred into services. Further, the TIR fails to address, adequately or at all, a number of the concerns raised in this Regulation 28 report. Since the purpose of a TIR to investigate a death to identify areas of concern with a view to learning lessons, it is a substantial concern that the TIR was incomplete in several respects; 9) Although [redacted] accepted that a number of issues had been highlighted by the inquest that he would be "feeding back" and "learning lessons from," it is a significant concern that almost two years have elapsed since Mr McDermott's death and lessons have not yet been learned, especially since the Trust had been in possession of the expert's report for over 3 months prior to the inquest.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 15 May 2017. I, the Area 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, [redacted] (Mr McDermott's parents), [redacted] (Chief Officer Chorley and South Ribble CCG), the Care Quality Commission and Beverley Humphrey (Chief Executive GMW). 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	**[DATE] 17 March 2017** **[SIGNED BY CORONER]**