	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Lancashire Care NHS Trust**
1	**CORONER** I am Dr J R H Adeley, Senior Coroner, for 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On I commenced an investigation into the death of Andrew Gus PEEBLES. The investigation concluded at the end of the inquest on 18 May 2016. The conclusion of the inquest was as set out in the attached Record of Inquest.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death of fully set out in the attached summing up and the jury's findings and conclusion
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) No entries were made by the RMN in the medical records specifically commenting upon the replies to questions in respect of self-harm or suicide, the only significant entries in the medical records on this subject being made by RGNs (2) No entries were made by the RMN after consultations/ACC T reviews with the deceased in the ACC T documentation resulting in no information being available to discipline officers managing Mr Peebles (3) No assessment by an RMN of a patient suffering obviously delusional symptoms on several occasions (4) No reading by the RMN of the ACC T documentation for collateral information necessary to assist in the diagnosis of a delusional disorder (5) RMN relying upon the summary of the ACC T documentation provided to her by the Senior Officer undertaking the ACC T review rather than assessing the documentation for herself to form a view of the information from a mental health perspective (6) RMN formed the view that Mr Peebles was not suffering from any mental health condition without having reviewed the ACC T documentation, discipline documentation or undertaking any mental health assessment prior to informing the deceased of her decision. (7) on referral on 25 May 2013 by and RGN who was concerned about Mr Peebles psychiatric state to two RMNs no record was made in the medical record of any such referral having taken place and no referral or assessment did subsequently take place (8) RMN remains in the clinical post within the trust and does not appear to have undergone any supervision or retraining

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	(9) the attendance at inquest by the healthcare manager without sufficient information to demonstrate that matters had improved, been resolved et cetera and having heard the suggestions to minimise future deaths by the expert [redacted] consultant forensic psychiatrist who advises at a national level on matters of prisoner safety, effectively responded that that wasn't the way the Trust undertook its assessments (10) the lack of any Trust internal investigation into the death
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 **8th August 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 Care Quality Commission who may find it useful or of interest. 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 13 June 2016  Signature for PRESTON AND WEST LANCASHIRE