REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Black Country Partnership, NHS Foundation Trust** **2. Chief Executive, New Cross Hospital**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 5 December 2016, I commenced an investigation into the death of the late Ms Abigail Baynham. The investigation concluded at the end of the inquest on 27 February 2017. The conclusion of the inquest was a short narrative conclusion of suicide. The cause of death was: 1a Hanging
4	**CIRCUMSTANCES OF THE DEATH** i) Ms Baynham had been known to Mental Health Services since 2010 with suicidal ideation precipitated by varying factors including illicit drug use, alcohol use, post-natal depression, relationship difficulties and social circumstances. ii) She had been referred by her GP to Healthy Minds in September 2016. The patient did not attend two appointments with Healthy Minds, had not responded to further contact attempts and was therefore discharged back to the care of her GP. iii) She was admitted to New Cross Hospital, Wolverhampton on 20th November 2016 following an overdose of paracetamol, Ibuprofen and fluoxetine. Following the overdose, the patient was assessed by a Senior Nurse Practitioner within the Mental Health Liaison Service (MHLS) on 22nd November 2016. Although initially reluctant to engage she did cooperate with the assessment which did not, at the time, identify delusional thinking, paranoid ideation, perceptual disturbances or psychosis. This, together with the patient having capacity to make decisions regarding her care meant she was not detainable under the Mental Health Act. iv) At the time, she was offered appropriate services that correlated with the outcome of the assessment. The patient declined further support from Mental Health services although the patient was made aware that she could

	change her mind if she wishes to access support in the future and was given the number for Penn Hospital. v) Later in the afternoon she left the hospital taking her belongings and stated she no longer wishes to be there. The Police and family were notified and later that day she returned home with her family. vi) Sadly, on the 29 November 2017 she was found deceased at her flat and had taken her own 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. Evidence emerged during the inquest that the when Ms Baynham had left hospital on the 22 November 2017, there was no further referral made back to Mental Health Liaison Service. This may have triggered a further assessment about her mental state and risk of self-harm.
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. 1. You may wish to consider setting up a protocol for referral to Mental Health Liaison Service in this situation when a patient absconds from hospital.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 29 May 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 Persons; Family. 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	**3 April 2017** **Mr Zafar Siddique** **Senior Coroner** **Black Country Area**