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**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of 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 30 January 2013, I commenced an investigation into the death of Kirsty Lisa Pritchard. The investigation concluded at the end of the inquest on 17 October 2014. The conclusion of the inquest was the deceased died from 1a. Strangulation by hanging and I recorded a conclusion of suicide contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** 1. Ms Pritchard had complex medical needs including a diagnosis of Personality disorder and obsessive compulsive disorder (OCD). She was admitted to Hallam Hospital on the 13 December 2012 and discharged on the 15th January 2013. She had a history of self harm and suicidal ideation. The multi disciplinary team who agreed to discharge her concluded that her continued stay in hospital was counter-productive and that community support was more suitable for her needs. 2. She was discharged from hospital on the 15 January 2013. The following day she expressed concerns to the Community Home and treatment team (CHTT) that she had thoughts of self harm and suicide. She was directed to contact the A and E hospital department for help. She stated she was going to buy duct tape and kill herself. 3. On the morning of the 20 January (around 9am), she again contacted the CHTT with concerns of self harm and suicide. She stated she had thoughts to hang herself and put a belt around her neck in the morning and frightened herself and called the team for support. She was advised to make a warm drink and the CHTT nurse would call her back to discuss possible support. A number of phone calls were made by the CHTT but there was no answer from Ms Pritchard. 4. At 12.25pm a further call was made and then the CHTT staff decided to pay her a home visit. On arrival at the property there was no response and the staff returned to their office. The Police were subsequently contacted and when they arrived they entered the property via the front door which was unlocked. She was found by the Police hanging with a belt used as a ligature around her neck and sadly pronounced deceased at the location by paramedics at 14:15 hrs.

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 Root cause analysis report by the Black Country Partnership NHS Trust confirmed that there were issues in relation to the communication of information. Specifically, the evidence presented at the inquest confirmed that CHTT contact with Ms Pritchard following discharge were not reported back to the inpatient Consultant in charge for review and assessment of risk of self harm in a timely fashion. (2) I am concerned that the ability to undertake effective management of patient risks of self harm and suicide ideation upon discharge may be compromised if the Consultant in charge or equivalent is not made aware of worsening symptoms and that effective systems are not in place to action this. (3) In addition, I am concerned that there were deficiencies in the systems in place for contacting and finding the patient. In this case the patient had contacted the CHTT with a real and immediate risk of self harm and it took over 5 hours to find her despite the fact that the Police managed to locate her very quickly when they were subsequently contacted.
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 12 December 2014. 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, Ms Pritchard's 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	**17 October 2014**