REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Joe Rafferty – Chief Executive** **Mersey Care NHS Foundation Trust, V7 Building, Kings Business Park, Prescot, Liverpool, L34 1PJ** **2. [redacted] – Senior Manager** **Cheshire Wirral Partnership, Countess of Chester Hospital NHS Trust, Countess of Chester Health Park, Liverpool Road, Chester, CH2 1UL**
1	**CORONER** I am Anita Bhardwaj, Area Coroner, for the area of Liverpool & Wirral
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 07/12/2016 I commenced an investigation into the death of **Lee Joseph HASTINGS SWAIN**, Aged **28**. The investigation concluded at the end of the inquest on 16/06/2017. The medical cause of death was: Ia Hanging The conclusion of the inquest was: Lee Joseph Hastings Swain took his own life whilst the balance of his mind was disturbed.
4	Lee Joseph Hastings-Swain was a 28 year old gentleman who suffered from Schizoaffective disorder and had been diagnosed with psychosis approximately 10-12 years ago for which he was prescribed Olanzapine and had received depot injections over the years. Lee was under Sefton mental health team (Mersey Care NHS Trust Foundation) and more recently Wirral Mental Health Team (Cheshire and Wirral Partnership NHS Trust). On 30 November 2016 Lee was found deceased hanging from the bannister at his home using a bed sheet. On the bed Lee had left an undated handwritten note suggestive of the fact he was suffering from severe emotional difficulties. Toxicology analysis showed nothing of significance which caused or contributed to Lee's death. It is unclear as to what Lee's intentions were when carrying out the act of self-harm but it is clear that he was suffering from mental health related symptoms and so his mind was disturbed. Lee had been under the care of Mersey Care NHS foundation since July 2005. During the years Lee's engagement was sporadic and he was placed on a Care Programme Approach(CPA), however subsequently he was taken off the programme on the basis of other clinical regular appointments. In March 2016 Lee moved to Wirral and Mersey Care discharged Lee from their services and referred him to Cheshire Wirral Partnership (CWP) via the General Practitioner (GP). In May 2016 The Wirral GP referred Lee to the CWP who failed to make contact with Lee

	and an assessment never took place. Within the Mental Health Services, the following failures occurred in the care and treatment of Lee: Mersey Care inappropriately removed him from the CPA when he clearly needed the continuity and engagement; Lee's care was not co-ordinated across services. Referrals through the GP were made rather than a transfer from service to service. If Lee had remained under the CPA the transfer would have been more effective – service to service; Despite Knowing that Lee was moving to the Wirral in March 2016 a referral letter with the clinical history was not sent until June 2016 which was an unacceptable delay; Cheshire Wirral Partnership Mental Health Services' Staff failed to adhere to Operational procedures in that the clinical notes were poor and inadequate. The notes were brief and did not fully detail decisions made or rationale for those decisions; CWP engagement with Lee fell short of expected standards, essentially comprising of appointment letters to his home address. The pattern of non-attendance should have triggered a more pro-active response to engage Lee with the service. There were a number of failures by the mental health services. It is unclear as to whether a more effective transfer from one service to another and thus earlier and more pro-active intervention would have changed the outcome for Lee, however, there were clear missed opportunities for further intervention to help and support Lee. A more co-ordinated approach from the mental health services may have given better opportunities to engage Lee so that he could have received the support and treatment he so desperately needed.
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. – A more co-ordinated approach from the mental health services is required when a user is being transferred from one NHS Trust to another. In this case if the user had still been on a Care Programme Approach there would have been a direct referral from service to service rather than through the GP but because he was taken off the programme the referral was made through the GP. This has delayed the intervention and the prevented effective information exchange on a user who was already subject to secondary care services. In effect this resulted in the user having no intervention for a number of months and entering the mental health system afresh when in fact the care should have been a seamless continuation. The Court would like you the Current Transfer / Referral Policy.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 14/08/2017. 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: 1. [redacted]s – mother 2. [redacted] - father 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	 **Anita Bhardwaj** **Area Coroner for the** **Liverpool & Wirral Coroner Area** **Dated: 16th June 2017**