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.** The Chief Executive, North West Boroughs Healthcare NHS Foundation Trust, Hollins Park House, Hollins Lane, Winwick, Warrington WA2 8WA
1	**CORONER** I am M Jennifer Leeming, HM Senior Coroner for the Coroner Area of Manchester West.
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 24th April 2017 I commenced an investigation into the death of Sharon Ann Halliwell, 48 years, born 28th February 1969. The investigation concluded at the end of the Inquest on 31st July 2017. The medical cause of death was:- Suspension by Ligature The conclusion of the Inquest was Suicide.
	CIRCUMSTANCES OF THE DEATH On the 18th of April 2017 Sharon Ann Halliwell was found deceased at her home address at [redacted]. The cause of her death was determined to be suspension by ligature. On the 7th of February 2017 she had been triaged at the Improving Access to Psychological Therapies Service and had given information that indicated that she was at risk of suicide. On the 18th of February 2017 she had a mental health assessment that indicated that she had been at high risk of suicide during the preceding two weeks. It was determined that she should be referred to a psychiatrist, but the referral was not made. Particularly, although both the triage and the mental health assessment were carried out by departments of the North West Boroughs Healthcare NHS Foundation Trust there was a lack of connectivity, described in the Inquest as "a gap" between the systems of the two services which meant that the information obtained at the triage on the 7th of February 2017 was not accessed by the nurse carrying out the assessment on the 18th of February.

5	**CORONER'S CONCERNS** Whilst other issues addressed in evidence had been addressed by the Trust the issue of lack of connectivity as described had not been fully addressed.	
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe that 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 the 29th of September 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] 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** **4th August 2017**	**Signed** **M Jennifer Leeming, HM Area Coroner**