REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Walsall Metropolitan Borough Council** **2. Chief Executive, Dudley and Walsall Mental Health Partnership** **3. Care Quality Commission- copied in for their information only.**
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 20 February 2019, I commenced an investigation into the death of Mr Peter Lawrence (PL). The investigation concluded at the end of the inquest on 3 June 2019. The conclusion of the inquest was an open conclusion. The cause of death was: 1a Total Spinal Cord Transactions b Traumatic Fracture And Dislocations Of Vertebral Column c Traumatic Bilateral Haemopneumothorax
4	**CIRCUMSTANCES OF THE DEATH** i) Mr Lawrence was a 48 year old gentleman who had been diagnosed with paranoid schizophrenia. ii) He had over 19 previous admissions to Psychiatric Hospitals when he was detained under the Mental Health Act. His last admission was at Dorothy Pattison Hospital on the 20 August 2017 to 26 October 2017. He successfully appealed against his detention to the mental health tribunal and was discharged from his section. During periods of relapse he was known to deposit faecal matter in his bath. iii) Attempts at follow up appointments were difficult and he disengaged from the service until 22 January 2018 when a joint home visit with the housing officer identified the poor state of his living environment. A care coordinator was also involved in trying to support him. iv) On 6 August 2018, he was found in the canal with an apparent attempt to self-harm. He was taken into Police custody and recalled to prison with no

	mental health act assessment taking place. v) He was released back into the community on 4 October 2018 and attempts were made to see him again. However he didn't allow entry to his flat and was still difficult to engage and meet. vi) At a joint home visit on the 22 January 2019, with his care coordinator and housing officer, it was noted that his flat was filthy with bird faeces and there was no electricity or gas. There was no bed and it appeared he slept on the floor with a sheet covered with a blanket. His bathroom was full of human faeces. vii) On the 8 February 2019, the deceased was found on the ground outside his flat having fallen from the balcony. He sadly died from the traumatic injuries sustained.
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 a number of contributory factors played a role in his death as highlighted as follows: 2. There was a lack of a joint multi-disciplinary/agency care plan (between Local authority and Mental Health Trust) which could have resulted in delays in a timely response to known relapse indicators. 3. A more assertive approach with consistency of care coordinator for a patient with a history of disengagement and relapse could possibly have been implemented reducing the likelihood of disengagement with services and promoted necessary concordance with medication. 4. A decision to admit to hospital under the mental health act following concerns being raised about self-care and disengagement could potentially have followed a coordinated MDT review and mental health act assessment and prevented deterioration in his mental health. 5. When PL was successful at the mental health tribunal and was discharged from Section 3 following his last admission to hospital in October 2017 against the view of the multidisciplinary team. The agencies involved placed too much reliance on this decision and follow up engagement and monitoring with PL reduced becoming inadequate.
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. Both agencies involved may wish to consider reviewing their approaches to multidisciplinary/agency care plans and risk assessments for community patients with these complex needs.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 27 August 2019. 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	**1 July 2019** **Mr Zafar Siddique** **Senior Coroner** **Black Country Area**