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. Lancashire and South Cumbria NHS Foundation Trust** **2. Family of Maziellie MacKenzie**
1	**CORONER** I am Philip Holden Assistant Coroner, for the coroner area of Lancashire and Blackburn with Darwen.
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** I commenced an investigation into the death of Maziellie MacKenzie. The investigation concluded at the end of the inquest on 01st November 2021. The conclusion of the inquest was A) Narrative conclusion. B) Short form conclusion - Suicide

4	CIRCUMSTANCES OF THE DEATH:-

Maziellie Mackenzie ('MM') was a looked after child and had been under the care of Cumbria County Council since 2016. She had a history of Mental Health issues and had been diagnosed with PTSD, Attachment Disorder, Anxiety and Depression.

Following a number of foster and residential placements which had broken down she had been placed in a tier 4 hospital catering for young people with Mental Health issues between the ages of 13 and 18 at the Cove Heysham and had been there since the 29/05/18.

She had a history of self harm which started initially with [redacted]. Whilst in the Cove there were several incidents of [redacted]

On the 23/06/18 she went on a third period of leave that day with 3 other residents and 2 members of staff to a [redacted].

At the end of the leave all residents including Maisie refused to return to the Cove. One member of staff was able to persuade one of the residents to return with her. The other member of staff followed two of the other residents who made off in a different direction to MM.

MM was discovered a few hours later by a group of youths in a [redacted] despite CPR an attending paramedic confirmed her death at 23 03 hours.

She took her own life and a subsequent note found in her room at the Cove evidenced her intention to do so.

In the Narrative conclusion failings at the Cove were identified in that :-

1. Formulation and risk management plans were not revisited when self-harm incidents occurred and did not include Mazie's needs and how they were to be met.

2. Her risk assessment held limited risk history and management plans in regard to Mazie's risk of going missing.

3. There was no written standardised procedure for agreeing and facilitating leave.

4. Communication of relevant information and record-keeping did not meet the required standard.

5. There were insufficient staff members with the 4 residents who were on leave.

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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] Expert evidence was heard (and accepted) at inquest that there was no written policy/document in place by the Trust which set out :- (1) The circumstances in which group leave from the Cove (and other tier 4 units) is granted and who is responsible for the granting of such leave. (2) That a mandatory risk assessment is required and setting out a list of factors/criteria that must be considered before any group leave is granted. (3) Setting out the staff to patient ratios for any group leave and identifying the criteria to be considered.
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 [DATE]. 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 family of Maziellie MacKenzie. 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	**[DATE] 31/12/21** **Philip Holden**