REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] Chief Operating Officer Swale CCG Brablefield Clinic Grovehurst Road Kemsley Sittingbourne ME10 2ST and 2. [redacted] Chief Operating Officer NHS Medway CCG Fifty Pembroke Court North Road Chatham, Maritime Chatham ME4 4EL
1	**CORONER** I am Allison Summers, Assistant Coroner, for the coroner area of Mid Kent & Medway
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 2nd January 2013 an investigation into the death of Lorna Frances Cullen was commenced. The investigation concluded at the end of the inquest on the 26th February 2014. I returned a short narrative conclusion.

4	**CIRCUMSTANCES OF THE DEATH** In the early hours of the morning of Sunday 23rd December 2012, Lorna Cullen was seen falling from the upper level of a multi-story car park. She suffered multiple injuries and died. No other person was involved in the event. There was a long history of mental health problems and at the time of her death she was under the care of the mental health services. Between the 17th and 21st December 2012 there was noticeable deterioration in her mental health. She referred to "living forever" and on the afternoon of the 22nd December 2012 she referred to herself as being "an action man". During the early evening of the 22nd December 2012 Lorna Cullen attended at the Emergency Department of Medway Maritime Hospital. She was triage assessed within 20 minutes of her arrival at the hospital. She was assessed as requiring a mental health assessment. She was noted to be "threatening suicide". She was not assessed as 'high risk, meaning that she did not need immediate assessment and treatment but was expected to be assessed within the standard 2 hour period from the time of the referral to the liaison psychiatry nurse on duty. Less than twenty minutes later and before any assessment had been carried out, Lorna Cullen left the hospital. The next time she was seen was when she was captured on closed circuit television falling from the car park.
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. – It became apparent that if the deceased had waited at the hospital she would not in fact have been seen until at least midnight and possibly later (more than twice the standard time). The reason for this was due to the fact that there was only one nurse on duty during the 'late' shift and in view of the fact that a mental health assessment takes between 2-3 hours the demand (the nurse on duty receives referrals from a number of different departments within the hospital) far exceeded the available staffing provision. It was apparent from the evidence of at least three witnesses that at the time of this death in 2012, patients in need of mental health assessment by the on-duty liaison psychiatry nurse were regularly waiting well in excess of 2 hours. The importance of a mental health assessment taking place as soon as possible after such a need has been identified is obvious. A specially trained psychiatry nurse is more likely to pick up on the more subtle indicators as to risk, that means it is more likely that appropriate management of that risk can be put into place thus affording the most effective preventive measures against self-harm and harm to others.

	During the course of the inquest I heard evidence that as a result of review additional resources had been awarded to facilitate increased staffing levels and to provide a 24 hour service (previously there were no liaison nurses on duty after midnight) thus providing continuation of services before and after midnight. I was advised that the additional levels of funding remain in place until at least the end of September 2014. The effect of these resources has been to significantly decrease the number of patients who require mental health assessments and who have to wait in excess of 2 hours. It has meant that staff can properly research a patient's history prior to or as part of the assessment which is not only essential so far as assessing the individual patient but is useful in assessing priority as between patients waiting to be seen. The matter of concern therefore relates to the long term (ie post September 2014) liaison psychiatry nurse staffing levels covering hospital emergency departments.
6	**ACTION SHOULD BE TAKEN** I recommend that action be taken to ensure that the following resources are available on a permanent basis (subject to any significant changes in demand due to for example a change in the arrangement of services): 1. The current liaison psychiatry nurse staffing levels. This means ensuring that there are at least two members of staff available during the day and late shifts. 2. The operation of a 24 hour liaison psychiatry service.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 6th May 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: 1. [redacted] (deceased's sister) 2. Kent and Medway NHS and Social Care Partnership Trust (Kay Learmond) 3. [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	**11th March 2014** **Allison Summers** **Assistant Coroner Mid Kent & Medway**