ANNEX A

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. Cumbria Partnership NHS Foundation Trust** **2. Department of Health** **3. NHS England** **4. Care Quality Commission** **5. Cumbria Clinical Commissioning Group** [redacted]
1	**CORONER** I am Ian Smith, senior coroner/area coroner/assistant coroner, for the coroner area of South & East Cumbria
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** On 1st August 2013 I commenced an investigation into the death of James Edward Boylan who was born on 3.6.64. The investigation concluded at the end of the inquest on 4th June 2014. The conclusion of the inquest was that James Edward Boylan died of 1a) hanging. I gave a conclusion that James Edward Boylan died as a consequence of his own actions whilst suffering from mental illness.
4	**CIRCUMSTANCES OF THE DEATH** Mr Boylan suffered chronically from anxiety for which he took medical advice including counselling from MIND, multiple appointments with his GP, several appointments with his Psychiatrist. On 20th July 2013, he was admitted to Dova Unit, Dane Garth, Furness General Hospital. In retrospect signs of an escalating level of his illness could be seen, but this was not appreciated at the time and the opportunity arose for him to engineer his own death by use of a phone charger cord and a rail in a bathroom designed for the use of disabled patients.
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) Removable rails in a bathroom designed for use by disabled people had been left inadvertently ever since the unit was opened. No one seemed to be aware that these rails were removable and certainly nobody had removed them. This provided a ligature point which would otherwise have been absent in a unit which was specifically designed

	to have as few ligature points as possible. The Coroner is concerned that this same situation may apply in other units and people need to be aware that ligature points in mental health units should be limited as far as humanly possible, and specifically that removable rails should be removed except when actually required. (2) Mr Boylan appears to have brought onto the ward a stanley knife blade. This was not discovered for several days. Mr Boylan only left the unit on one occasion and so could only have brought the blade onto the unit either 7 days before his death or 3 days before his death. The Coroner asks that thought be given to more robust searching of patients' property. The origin of the cord which Mr Boylan used is not clear. It may have been his own, but the policy of having these kept centrally so that patients do not have access direct to them was not adhered to on this occasion, and so again Mr Boylan had access to something which he could use to hang himself with. (3) There were numerous events over the 7 days during which Mr Boylan was present on the ward for someone with an overall view to realise that his condition was escalating and that he might become a danger to himself, but because no one person had overall knowledge of all the facts, this was not recognised. It is suggested that communication be improved in any way in which the Trust thinks possible. (4) GRIST: Assessments should be more rigorously completed and disseminated so that staff are aware of their contents, because in relation to Mr Boylan this did not appear to have taken place so that an opportunity for communication of information was lost.
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 2.8.14. 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: Cumbria Partnership NHS Foundation Trust; Department of Health; NHS England; Care Quality Commission; Cumbria Clinical Commissioning Group and copies to [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	**6 June 2014 Ian Smith H M Senior Coroner South & East Cumbria**