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,** **Cheshire and Wirral Partnership NHS Foundation Trust** **2. The Chief Executive,** **Lancashire Care NHS Foundation Trust**
1	**CORONER** I am Alan Wilson, Senior Coroner, for the area of Blackpool & Fylde
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 21st June 2013 an investigation commenced into the death of **Stephen James Morris**, aged **44 years**. The investigation concluded at the end of the inquest on 15th October 2013. The record of the inquest confirmed as follows: The Medical cause of death was 1a Aspiration pneumonitis 1b Inhalation of Gastric Contents 1c Combined toxic effects of Lithium and Mirtazapine The conclusion of the Coroner as to the death was Stephen Morris took his own life
4	**CIRCUMSTANCES OF THE DEATH** As regards the circumstances by which the Deceased came by his death, the inquest concluded that Stephen James Morris had previously been diagnosed as suffering from bi-polar affective disorder a number of years ago. Having spoken on the telephone to his family during the evening of Sunday 16th June 2013 he was found deceased at approximately 1015 hours the following morning lying in the bath at the flat where he resided. A subsequent post mortem examination confirmed the presence of high levels of mood stabilising and anti – depressant medication the combined effects of which proved fatal.
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. – At the conclusion of the inquest, I indicated to the Properly Interested Persons that I proposed to write to the Trust by way of a report in accordance with the provisions of paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009. During the Inquiry, I received evidence that during the later months of his life Stephen had spent time residing mostly in the Chester / Frodsham region in Cheshire, but also in Blackpool. At the inquest his former Care-coordinator informed the court that for a number of weeks during March / April 2013 Stephen had been residing in Cheshire where concerns had been raised that his condition had deteriorated. The Care – coordinator became aware that Stephen was returning to the Blackpool area for what she understood to be a holiday period. Stephen was by that stage known to mental health services in the Blackpool area. The Blackpool Complex Care & Treatment Team had last had involvement with Stephen on 7th March 2013 when the team had closed their service in respect of Stephen having been told he was moving back to the Chester area. Although upon his return to the Blackpool area Stephen did ring the Blackpool team prompting contact with the Care Co-ordinator in Cheshire, the Care Co-ordinator acknowledged that more information could have been provided to the Blackpool mental health professionals as regards what she knew in relation to Stephen's mental health since the Blackpool team had last had dealings with him, even if he was only expected to be in Blackpool for a short period of time. Having concluded this inquest, I now write to the Trust to confirm that in my view the Trust should take action because: • I am concerned that there was a limited exchange of information as regards Stephen and his mental health between the mental health professionals in Cheshire and their counterparts in Blackpool. • By the time that Stephen came to Blackpool for what turned out to be the final time the professionals in Blackpool did not have a detailed picture of how Stephen had presented during recent weeks in relation to his mental health. • When individuals with a similar mental health history as Stephen do move from one area of the country to another there is the potential for a mental health team to find themselves with less detailed relevant information than may be the case for a similar individual who has recently been residing within the immediate area. I am concerned that the quality of exchange of information needs to be such that when mental health professionals find themselves dealing with such an individual that they have as much relevant information as possible to be able to assess the risk such a patient poses and to respond accordingly. I would therefore be obliged if the Trust would write to me in due course to confirm what steps if any the Trust proposes to take to address these concerns.
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 23rd January 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 The family of Stephen Morris The Chief Coroner of England & Wales 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	*A. A. Wilson* **Alan Wilson** **Senior Coroner for the area of Blackpool & Fylde** **Dated: 27th November 2014**