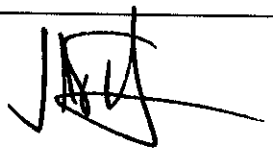
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Mr Neil Carr Chief Executive South Stafford and Shropshire Healthcare NHS Foundation Trust Trust Headquarters Mellor House St. George's Hospital Corporation Road Stafford ST16 3AG
1	**CORONER** I am John Penhale Ellery, Senior Coroner, for the coroner area of Shropshire, Telford & Wrekin
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 30th May 2014 I, with a Jury, concluded the Inquest into the death of the late Peter James FAREBROTHER. The Jury returned a narrative conclusion as follows: The deceased Mr Peter James Farebrother took his own life whilst the balance of his mind was disturbed. In addition it is the decision of the Jury that the risk of returning Mr Farebrother's belt and placing Mr Farebrother on general observation was not fully recognised. These two factors combined contributed to Mr Farebrother's death.
4	**CIRCUMSTANCES OF THE DEATH** The late Mr Farebrother had been admitted as an emergency patient to the Redwood Centre on Oak Ward the 17th July 2013. He was admitted to Holly Ward 2 days later with the intention of later being admitted to Pine Ward. That transfer did not take place until the evening of the 22nd August 2013. 2 days later on the 24th August 2013 Mr Farebrother was found deceased hanging from a belt ligature attached to the en-suite shower door in his room (room 11) at Pine Ward.
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) The delayed transfer to Pine Ward coming at the end of an evening shift prior to handover to the night shift. (2) The failure by the receiving staff on Pine Ward a) during the remainder of the evening shift or b) at any time during the night shift to recognise that Mr Farebrother had been on constant watch up to and including the transfer and that no assessment had taken place changing that status. (3) The lack of personal knowledge in the handover procedure and the limited time the assessing assistant practitioner had at the start of the morning shift to read Mr Farebrother's papers. (4) The assessment may well have resulted in a higher observation level and the basis on which it was made, consciously or subconsciously, may have been flawed by the earlier breakdown in information. (5) The decision to return the belt to Mr Farebrother. It was the same belt which a) Mr Farebrother later hanged himself with and b) had resulted in Mr Farebrother having been on constant observation at Holly Ward. Whilst other ligatures may still have been available to Mr Farebrother by removing the belt the most obvious ligature would have been avoided. (6) The perception that Pine Ward may be ligature free may have lowered risk awareness. Staff may have felt that the need for higher observation and/or ligature avoidance had been reduced by the environmental safety features on Pine Ward itself, whereas the underlying risk remained. (7) The sloping door was intended to prevent or reduce the risk of hanging. Mr Farebrother's case has indicated that that is not so. No change has been made to the door and it is therefore possible that this means of ligature attachment could happen again. The door was manufactured and delivered for purpose and therefore this concern should also be shared with the manufacturer. Consideration should also be given whether there is a need for an en-suite shower door, balancing the patient's rights of privacy and dignity over risk of self-harm.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 15th August 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. Lanyon Bowdler solicitors for the family 2. Capsticks solicitors for the Trust 3. Leaderflush Shapland – door manufacturer's 4. The Care Quality Commission 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	 20th June 2014 John Penhale Ellery