REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive Officer** **East Lancashire NHS Foundation Trust** **Trust Headquarters** **The Royal Blackburn Hospital** **Haslingden Road** **Blackburn BB2 3HH**
1	**CORONER** I am Michael Singleton, Senior Coroner for the Coroner area of Blackburn, Hyndburn & Ribble Valley.
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 28th January 2018 I commenced an investigation onto the death of Jacqueline Williams aged 42. The investigation concluded at the end of the Inquest which was concluded on the 28th October 2015. The conclusion of the Inquest was that Jacqueline Williams had committed suicide.
4	**CIRCUMSTANCES OF THE DEATH** On the evening of Monday 26th January 2015 Jacqueline Williams was conveyed by ambulance to the Royal Blackburn Hospital where she was triaged and assessed to be at moderate risk of self-harm. A decision was made that she should be referred directly to the Mental Health Liaison Team. Due to a breakdown in communication between the triaging nurse and the Mental Health Liaison nurse no actual referral was accepted by the Mental Health Liaison Team. Having been placed in a cubicle within the emergency department at the Royal Blackburn Hospital Jacqueline Williams hanged herself from the central observation light using the electrical cord tied around her neck.
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 further deaths will occur unless action is taken. In the circumstances it is my duty to report to you the **MATTER OF CONCERN** is as follows: - That the process of referral to the Mental Health Liaison Team was subject to human error and that the systems in place failed to provide for such mistakes to be easily identified and rectified. In particular there was no opportunity for staff in the emergency department to see confirmation that a referral had been accepted, the time of that referral and the expected time when a mental health assessment would take place. Likewise the Mental Health Liaison Team did not have a process that whereby they were able to identify those patients that the staff in the emergency department believed had been referred and were awaiting assessment.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 21st December 2015. I, the Coroner, may extend this 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 person, namely: [redacted] Lancashire Care NHS Trust 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	**02 November 2015** **Signed by:** ..... **H M Senior Coroner for Blackburn, Hyndburn & Ribble Valley**

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive Officer** **Lancashire Care NHS Trust** **The Innovation Centre** **1 Evolution Park** **Haslingden Road** **Blackburn BB2 2FD**
1	**CORONER** I am Michael Singleton, Senior Coroner for the Coroner area of Blackburn, Hyndburn & Ribble Valley.
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 28th January 2018 I commenced an investigation onto the death of Jacqueline Williams aged 42. The investigation concluded at the end of the Inquest which was concluded on the 28th October 2015. The conclusion of the Inquest was that Jacqueline Williams had committed suicide.
4	**CIRCUMSTANCES OF THE DEATH** On the evening of Monday 26th January 2015 Jacqueline Williams was conveyed by ambulance to the Royal Blackburn Hospital where she was triaged and assessed to be at moderate risk of self-harm. A decision was made that she should be referred directly to the Mental Health Liaison Team. Due to a breakdown in communication between the triaging nurse and the Mental Health Liaison nurse no actual referral was accepted by the Mental Health Liaison Team. Having been placed in a cubicle within the emergency department at the Royal Blackburn Hospital Jacqueline Williams hanged herself from the central observation light using the electrical cord tied around her neck.
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 further deaths will occur unless action is taken. In the circumstances it is my duty to report to you the **MATTER OF CONCERN** is as follows: - That the process of referral to the Mental Health Liaison Team was subject to human error and that the systems in place failed to provide for such mistakes to be easily identified and rectified. In particular there was no opportunity for staff in the emergency department to see confirmation that a referral had been accepted, the time of that referral and the expected time when a mental health assessment would take place. Likewise the Mental Health Liaison Team did not have a process that whereby they were able to identify those patients that the staff in the emergency department believed had been referred and were awaiting assessment

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 21st December 2015. I, the Coroner, may extend this 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 person, namely: [redacted] East Lancashire Healthcare NHS Trust 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	**02 November 2015** **Signed by: .....** **H M Senior Coroner for Blackburn, Hyndburn & Ribble Valley**