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 Foundation Trust** **Sceptre Point** **Sceptre Way** **Walton Summit** **Preston** **PR5 6AW**
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 13th day of October 2015 I commenced an investigation into the death of Tracey Marie Lynch aged 39 years. The investigation concluded at the end of the Inquest which was concluded on the 19th May 2016. The conclusion of the Inquest was that Tracey Marie Lynch had committed suicide.
4	**CIRCUMSTANCES OF THE DEATH** Tracey Lynch, who was suffering from emotionally unstable personality disorder was admitted onto Stevenson Ward, a secure psychiatric unit at The Harbour in Blackpool on the 17th March 2015 following an assessment and having attempted to hang herself from a tree. At a care programme approach meeting held on the 22nd June 2015 it was agreed that she should be discharged to a suitable rehabilitation unit. Following various assessments and the obtaining of funding a place was identified at Oswald House, in Oswaldtwistle. It was agreed that she would be transferred on the 28th September 2015 and it was recognised that the transition would be stressful and would lead to an even higher risk of suicide. That risk was not managed in that no final discharge meeting was held; no familiarisation visits were arranged for Miss Lynch and appropriate escorted transport was not arranged. En route to Oswald House a major incident occurred leading to Miss Lynch being Sectioned under the Mental Health Act and returned to The Harbour but placed on a different ward and with a different responsible clinician. There was a failure by The Harbour to carry out any assessment as to her then fitness to be discharged and a failure by Oswald House to carry out any assessment in relation to her suitability to

	be admitted to Oswald House given the change in her presentation. She was transferred to Oswald House on the 5th October 2015 and at approximately 3pm on the 9th October 2015 she hanged herself in the wardrobe of her room at Oswald House intending thereby to bring about her own demise.
5	**CORONER'S CONCERNS** During the course of the Inquest the evidence revealed matters giving arise 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 **MATTERS OF CONCERN** being as follows: - 1. Despite the fact that there had been a clear change in the presentation of Tracey Lynch following the CPA Meeting on the 22nd June and despite the fact that arrangements for discharge were not in place until the 28th September 2015 no final discharge meeting was held, that is despite the fact that the responsible clinician, [redacted] the care co-ordinator [redacted] and the deputy manager from Oswald House [redacted] had all indicated that they wished for there to be a final discharge meeting. There seemed to be no system in place to ensure that such a meeting would take place and in order to ensure that appropriate management would take place of the discharge to a rehabilitation unit. 2. The evidence was that familiarisation visits would have been of considerable assistance to Miss Lynch in the lead up to her discharge to Oswald House. Despite that being accepted there appeared to be no system in place to ensure that such familiarisation visits would take place. 3. The evidence was that [redacted] the mother of Tracey Lynch, had alerted the care co-ordinator and the responsible clinician with her concerns that her daughter's state of mind was such that unless she was properly and appropriately escorted in the transport from The Harbour to Oswald House that she would attempt to jump from the motor vehicle. Those concerns were not addressed such that on the 28th September when only escorted by the occupational therapist who was driving the vehicle Miss Lynch was able to grab the steering wheel and cause a serious accident on the M55 motorway. Despite the fact that that risk had previously been identified there was no attempt to seek to manage that in an appropriate way. 4. Having been detained by the Police and having then been assessed by Mental Health Practitioners Tracey Lynch was then detained under Section 3 of the Mental Health Act 1983. She was taken from Preston Police Station to The Harbour at Blackpool. She was placed on a different ward and with a different responsible clinician, [redacted] Without carrying out any form of assessment whatsoever and with only a cursory glance at previous records [redacted] immediately rescinded the Section 3 and without any consideration of the change in circumstance and presentation of Miss Lynch arranged for her immediate discharge to Oswald House. The evidence was that the Consultant Psychologist, [redacted] who had previously been dealing with Miss Lynch attempted to contact [redacted] but her offer of assistance was refused. Having been detained for a second time there was no assessment and no care programme approach meeting arranged. That appeared to be a serious systems failure.
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 1st August 2016. 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] Pathways North West Limited 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	**06 June 2016** **Signed by:** ..... **H M Senior Coroner for Blackburn, Hyndburn & Ribble Valley**