REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Ms S.Cumiskey, Chief Executive of Bowmere Hospital**
1	**CORONER** I am Nicholas Rheinberg, senior coroner for the coroner area of Cheshire
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 5th June 2015 an investigation into the death of Janet Esme Millar was commenced. The investigation concluded at the end of the inquest on 1st December 2016. The conclusion of the inquest was that the deceased, whose medical cause of death was 1(a) hanging, had died by suicide.
4	**CIRCUMSTANCES OF THE DEATH** The deceased who suffered from schizophrenia had been admitted to the Rosewood Unit of your hospital for rehabilitation. Ultimately she was held subject to section 3 of the Mental Health Act. In common with the majority of those diagnosed with a mental illness, the deceased was addicted to nicotine through cigarette smoking. The inquest heard evidence to the effect that Bowmere Hospital had, prior to the admission of the deceased, adopted a non-smoking policy for patients and staff. The deceased showed no interest in breaking her addiction and quitting smoking although there was evidence to the effect that she had been offered nicotine replacement therapy. There was a suspicion that some members of the nursing staff, although readily enforcing the smoking ban, were not fully engaged in addressing the problem of nicotine addiction and that this revealed a possible training deficit.
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. – Most of those admitted to your hospital are addicted to nicotine. Some are suicidal. You have recognised that hand in hand with a non-smoking policy it is necessary to break the cycle of addiction and support those who are withdrawing. It would be a concern if there is a training deficit as identified in the previous section and this would need to be addressed.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 9th February 2017. 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 [redacted] and the CQC. 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	**15th December 2016** **Nicholas Leslie Rheinberg]**