REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Lancashire Care NHS Foundation Trust**
1	**CORONER** I am Rachel Galloway, assistant coroner, for the coroner area of North and East Lancashire, Preston and South West Districts.
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 14th November 2016 an investigation was commenced into the death of Robert Cardwell. The inquest took place over 2 days and concluded on the 23rd June 2017. The conclusion was one of Suicide. The medical cause of death was 1a hanging.
4	**CIRCUMSTANCES OF THE DEATH** **From June 2016 Mr Cardwell was under the care of the Home Treatment Team ("HTT") at the Trust. Thereafter, he failed to attend a number of appointments offered to him with crisis practitioners and the Psychiatrist. On the 7th July 2016 Mr Cardwell was discharged from the HTT following an MDT meeting. Information about the reason for his non-attendance had not been passed on to the team before they decided to discharge him.** **On the 10th August 2016, Mr Cardwell was not discussed at the HTT MDT meeting despite Mr Cardwell's request for clarification as to whether he was due an appointment.** **On the 16th September 2016 a message was left with the HTT by [redacted] (ex-wife of Mr Cardwell) seeking assistance in respect of Mr Cardwell. The crisis practitioner did not follow up this message and neither Mr Cardwell nor [redacted] were contacted by the HTT. The system in place for dealing with emails to staff in this context has now changed.** **On the 18th September 2016 and 22nd September 2016 Mr Cardwell was in police custody. On the 26th or 27th September 2016 he informed a friend that he was very low and in a dark place. He told her that he had made a contraption to hang himself – this was a football scarf. He sent her a photo of the scarf. On the 28th September 2016 [redacted] received a video call from Mr Cardwell where he asked if she wanted him dead. He was found deceased at his home address on the 29th September 2016 having used a Burnley football scarf as a ligature and hung himself from the door handle in the sitting room. Police enquiries revealed that Mr Cardwell had been drinking on the 28th September 2016 and he had mentioned to another friend the idea of using a Burnley scarf to hang himself.**

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. – **CONCERN 1** **On The 6th July 2016 a nurse at the Trust contacted Mr Cardwell to find out why he had not attended his appointment with the Psychiatrist that day. Mr Cardwell told the nurse that he had been unable to attend the appointment because he had no petrol. He also advised that he had no phone credit and had therefore been unable to contact them. Mr Cardwell reported that his ex-partner had stolen his bankcard and that all the money had gone from his account. The nurse advised that this information would be passed to the MDT for their consideration the following day. Mr Cardwell wanted another appointment but he said it would have to be a home visit.** **Whilst Mr Cardwell was discussed at the MDT meeting on the 7th July and discharged, I found on the evidence that the message explaining his non-attendance and requesting a further appointment was not relayed to the MDT. Had that message been relayed to the MDT, I found that Mr Cardwell would have been offered a further appointment and would not have been discharged at that time. This failure in communication is a matter of concern. I am concerned about the process by which messages are relayed from service users to the MDT team. The nurse explained that the information was passed on to be taken up by the Duty Worker and it should then have been reported to the team. The nurse also recorded the contact in Mr Cardwell's clinical record but these were not looked at during the course of the MDT meeting.** **CONCERN 2** **On the 6th August 2016 Mr Cardwell was seen in hospital by a member of the liaison team following a significant overdose. He was later discharged from hospital and he queried with the HTT on the 9th August 2016 (on attending West Strand House in person) whether he was due a follow-up with the HTT. Mr Cardwell was told that the MDT would be asked the following day and that someone would contact him from the team to let him know. I found that the message was - on this occasion - relayed by the Duty Practitioner to the MDT on the 10th August 2016. However, the MDT did not discuss Mr Cardwell and nothing was recorded about him. No-one contacted Mr Cardwell back to advise him as to whether or not he would have an appointment with the HTT. I heard evidence that the MDT meeting could be disorganised. I am concerned that Mr Cardwell was not considered by the team, despite the message being handed over to them. I am also concerned about a lack of record keeping during the MDT. Even where patients are discussed, the notes appear to be very brief.**
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 August 2017. I, the assistant 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 the following Interested Persons, namely [redacted] (ex-wife of the deceased), who may find it useful or of interest. 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.
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