REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Philip Dunne MP, Minister of State for Health c/o Ministerial Correspondence and Public Enquiries Unit Department of Health Richmond House 79 Whitehall London SW1A 2NS
1	**CORONER** I am Alan Wilson, Senior Coroner, for the area of Blackpool & Fylde
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** I conducted an investigation into the death of Sara Antonia MORAN, known as Sally, and the inquest that was held over the course of two days on 9th and 10th April 2018. The medical cause of death was 1a morphine toxicity The conclusion of the Coroner as to the death: DRUG RELATED In paragraph 3 of the Record of Inquest I recorded as follows: Sara Moran, known to her family as Sally, had a history of mental health problems and drug abuse. At approximately 1030am on Saturday 22nd April 2017 police attended at her home address after a concern was raised for her welfare. The property was found to be secure and entry was forced. Sally had made efforts to barricade herself into her bedroom where she was located on her bed and in close proximity to a large number of blister packets of medication. The last known communication with her was no later than 0730 hours on Tuesday 18th April 2017. She had most likely been deceased since at least that afternoon. A subsequent post mortem examination confirmed she had died from the effects of voluntarily ingesting a large quantity of morphine.

4	**CIRCUMSTANCES OF THE DEATH** Sara had a history of mental health issues but had not been detained in a mental health facility nor been a voluntary patient in such a facility for some time. Historically she was known to fail to engage with mental health services and had previously been discharged from services regularly. At the time of her death she was diagnosed with Recurrent Depressive Disorder (F.33) and Mental & Behavioural Disorder due to Multiple Drug Use (F.19). On 5th April 2017 her General Practitioner, with whom she had a good relationship, referred her for an urgent assessment of her mental health when she presented as paranoid and at one point threatened to throw herself in front of a train A mental health professional was able to speak to her Mother later that day and decided she could spend the night at her Mother's address on the understanding that she attend a previously planned appointment for an assessment scheduled for the next day. This was regarded as a reasonable decision. However, she did not attend and could not be contacted. After a Multi-Disciplinary Meeting held on 7th April 2018 she was sent a letter asking her to contact the team if she wanted an assessment and indicating that In the event no contact was received from her during the following ten day period she would be discharged from mental health services and back to her GP. On 10th April 2017 mental health services confirmed there was some contact with Sara and arrangements were made for an appointment on 13th April 2017 but she did not attend. On 15th April 2017 the mental health team were contacted by the police who were with Sara at the time and the police were concerned about leaving her on her own although she had not expressed any suicidal intent. She would not go to hospital for assessment. That conversation appears to have concluded on the basis that the police were under the impression that the mental health professionals would be in contact with Sara but the Deputy Team Leader with whom they spoke told the inquest she had understood that Sara had expressed suicidal thought and that the police had called for an ambulance which would take her to hospital where she would then be assessed. I preferred the police version on this disputed piece of the evidence. The mental health team tried to make contact with her but she again failed to engage. There was no further contact with her. Ultimately she was reported as missing by a concerned neighbour who had last seen her on the morning of the 18th April 2017. By the morning of the 22nd April 2017 the police felt it necessary to force entry to her property where she was found deceased. It was determined at the inquest that although a letter felt to be in her handwriting was found in her property which may be interpreted as an indication of intent to harm herself it was undated and may not have been written around the time of her death. The criminal standard of proof was not satisfied to the extent that the Coroner could be sure beyond a reasonable doubt Sara intended to take her own life. During the inquest evidence was heard from a [redacted], an Investigation and Learning Specialist who had performed the role of Investigation Lead as regards the Lancashire Care NHS Foundation Trust post incident review. His evidence was constructive. He informed the inquest that in his view at the time of the above events

	pertaining to Sara Moran the Crisis Resolution and Home Treatment Team staff were trying to service the needs of too many Service Users when taking into account the numbers of staff available and that this over capacity would in his view have affected the quality of the service afforded to Sara Moran.
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. Having reviewed the inquest evidence, and notably the evidence of [redacted] referred to above, I informed the court that I would write this report. I am concerned that if mental health professionals are expected to provide care to an excessive number of service users – many of whom inevitably pose significant challenges – then there a genuine risk of future deaths arises as a result of this. Sara Moran had a history of drug and mental health problems. Although I did not find that the care afforded to Sara contributed to her fatal outcome this does not prevent me from writing this report. If mental health professionals are finding themselves struggling to provide the level of service that Service Users such as Sara require then such demands in my judgement inevitably pose a significant risk that one or more such Service Users may not receive the level of attention they need and with potentially fatal consequences. At the conclusion of the inquest, I indicated to the Properly Interested Persons that I proposed to write to the Department of Health by way of a report in accordance with the provisions of paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 24th June 2018. 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:

	• Family of Sara Moran • Chief Executive, Lancashire Care NHS Foundation Trust. • Chief Executive, Blackpool Council. 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	**A.A.Wilson** **Alan Wilson** **Senior Coroner for Blackpool & The Fylde** **Dated: 28th April 2018**