Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 Cheshire and Wirral Partnership NHS Foundation Trust

1 CORONER

I am Andre REBELLO, Senior Coroner for the area of Liverpool and Wirral

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 20/12/2018 I commenced an investigation into the death of Barry Marshall Fullarton aged 79. The investigation concluded at the end of the inquest on 17 May 2019. The conclusion of the inquest was:

Barry Marshall Fullerton died by Suicide, when suffering from a reactive depressive illness, which affected his mood in the morning.
The Cause of death was:

I a Multiple injuries
I b----------
I c ----------
II ----------

4 CIRCUMSTANCES OF THE DEATH

On the 17th December 2018 at 9.05 Barry Marshall Fullerton was certified as having died beneath the balcony of his bedroom at [redacted], West Kirkby. There was a chair placed on the balcony above. It is found that he used this intentionally to fall over the balcony with fatal intent. In October 2018, Mr Fullarton had suffered a stroke which was more likely than not the cause of a reactive depressive illness which included a significant diurnal variation in mood (low mood in the morning and normal affect in the afternoon). The depressive illness manifested in thoughts of intentional self-harm and suicide. On the 14th December 2018, Barry Fullerton underwent a mental health assessment. This took place in an afternoon and he was assessed as being safe to go home. He was on anti-depressant medication (found present in post-mortem toxicology) but he had declined to engage in an assessment of appropriate psychological therapy plan. It is unclear as to whether a mental health assessment in a morning would have assessed different needs.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

Those carrying out mental health assessments should have regard to how a mental disorder manifests in a patient. In this case, the diurnal nature of the reactive depressive illness was evident from the medial records such that an assessor could have documented that the assessment at a particular time when mood was good may not be valid when in low mood.

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 12 July 2019. 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.

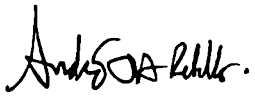
8 COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons Mr Fullarton's family.

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



Andre REBELLO
Senior Coroner for
Liverpool and Wirral
Dated: 17 May 2019