




for Lancashire & Blackburn with Darwen

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO: The Chief Executive Officer Lancashire Care NHS Foundation Trust Sceptre Point Sceptre Way Walton Summit Preston PR5 6AW</p>
1	<p>CORONER</p> <p>I am Neil Cronin Assistant Coroner for Lancashire & Blackburn with Darwen</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On the 3rd July, an investigation into the death of David Clark aged 64 commenced. The investigation concluded at the end of the inquest on the 6th February 2020. The conclusion of the inquest was that he had taken his own life.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>The deceased was compulsorily detained at the Orchard Hospital under section 3 of the mental health act. He had a diagnosis of bipolar disorder. On the 26th June 2019 at around 19.26 hours he left the Orchard on unescorted leave and was found the following morning and in the Lancaster canal. The cause of death was drowning.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <ol style="list-style-type: none">(1) That documentation in relation to leave was not completed fully and incorrect forms used(2) That the AWOL procedure was not followed(3) That a handover was not undertaken between Safety and Security workers(4) That there was a lack of training on policy and procedure(5) That there remains outstanding an appropriately sufficient action plan

6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion, action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 2nd April 2020. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons Farley's, Solicitors for the family.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>Dated 06/02/2020</p> <p>Signature </p> <p>Assistant Coroner for Lancashire & Blackburn with Darwen</p>