Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 NHS England** **2 Chief Coroner's Office** **3 CQC**
1	**CORONER** I am Johanna THOMPSON, Assistant Coroner for the coroner area of Sefton, St. Helens and Knowsley
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 27 August 2020 I commenced an investigation into the death of Sergio DUNKLEY aged 45. The investigation concluded at the end of the inquest on 06 May 2022. The conclusion of the inquest was 'Suicide'
4	**CIRCUMSTANCES OF THE DEATH** Sergio's mental health deteriorated during 2020. He made threats to end his life culminating in his voluntary admission to a mental health ward at Hartley Hospital, Southport on 24th July 2020. On his arrival at hospital Sergio was placed under regular observations, requiring that he be checked every 15 minutes. Upon being formally admitted, observations were continued at the same level until the following day when they were reduced to once per hour. During his hospital admission Sergio received regular and appropriate input from ward staff and clinicians. Sergio was last seen alive at approximately 12.30am on 18th August 2020. He was found to have taken his own life by [redacted] shortly before 01.30am on that same morning. The Trust has made the following admissions: The rationale for the change in Mr Dunkley's observation levels on 25th July was not recorded. The formal written risk assessment document commenced for Sergio on 25th July 2020 was not updated after 4th August 2020. The following facts were found but were not directly causative of Sergio's death on 18th August 2020 The hospital staff did not adequately record their rationale for assessment of Sergio's risk of suicide between 4th and 17th August 2020. On 17th August 2020, Sergio presented as significantly anxious when plans for his hospital discharge were being discussed, and there was a failure by staff to carry out a formal assessment as to whether he was at increased risk of suicide on that day.
5	**CORONER'S CONCERNS**

	During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) (1) That there is no statutory requirement nor any current regulations which specifically require the doors within newly build mental health units to be fitted with ligature alarms. (2) That whilst Health Building Note 03-01 as published by the Department of Health gives guidance that " All fixtures and fittings should be antiligature" the requirement to do so is not stated to be mandatory. (3) That inspection and approval of newly built mental health units contains no mandatory requirement for the checking as to the placement of ligature alarms.
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 July 07, 2022. 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 – [redacted] reprsented by Farley's Solicitors** **MERSEY CARE NHS FOUNDATION – Represented by Hill Dickinson** I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 12/05/2022**  **Johanna THOMPSON** **Assistant Coroner for** **Sefton, St. Helens and Knowsley**