	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1) Lancashire and South Cumbria NHS Foundation Trust;** **2) Blackpool Teaching Hospitals NHS Foundation Trust;** **3) Lancashire County Council;** **4) Nightingales Care Limited; and** **5) Zion Care Limited.**
1	**CORONER** I am Tim Holloway, Assistant Coroner for the coroner 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** Following referral to the Coroner's Office on 12th October 2020, the Senior Coroner for the coroner area of Blackpool & Fylde commenced an investigation into the death of Margaret Florence Joyce Stringer, aged 81. The investigation concluded at the end of the inquest on 30th May 2022, the inquest having been heard before me. The conclusion of the inquest as to the medical cause of death was: 1a Hanging I reached a narrative conclusion, as follows: "Suicide, the Deceased having taken her own life, in part because appropriate precautions were not taken to prevent her from so doing in the circumstances that the information about her risk to herself which was conveyed to those caring for her was incomplete and the extent of the risk of her so doing and the context in which that risk may eventuate were not fully recognised. The Deceased's suicide was contributed to by the return to her of the item which she used as a ligature when it had been identified that, for her own safety, she should not have it in her possession."
4	**CIRCUMSTANCES OF THE DEATH** . The following determination as to how, when and where the Deceased came by her death was reached at the conclusion of the inquest: "Margaret Florence Joyce Stringer died between 18.35 hours and 19.00 hours on 10th October 2020 in the bathroom adjoining her room in Nightingales Nursing Home, 355a Norbreck Road, Cleveleys, Blackpool, FY5 1PB. Having been seen by a member of staff at around 18.35 hours on the evening of 10th October 2020, Mrs Stringer was left alone in her room. Thereafter she proceeded to [redacted]. Mrs Stringer had been discharged to Nightingales Nursing Home on 24th September 2020 following an admission to The Harbour mental health hospital ('The Harbour') under section 2 of the Mental Health Act 1983 which had commenced on 15th April 2015, after receiving treatment at The Harbour as an involuntary patient under section 3 of the Mental Health Act 1983 from 12th May 2020 to 26th August 2020 and after receiving treatment as a voluntary patient thereafter to the point of her transfer to Blackpool Victoria Hospital on 6th September 2020. Margaret presented a high risk of suicide throughout. Mrs Stringer had suffered longstanding mental illness and, in the days preceding her death, there had been an apparent deterioration in her mental health. She took her own life, in part because appropriate precautions were not taken to prevent her from so doing in the circumstances that the information about her risk to herself which was conveyed to those caring for her was incomplete and the extent of the risk of her so doing and the context in which

	that risk may eventuate were not fully recognised. The Deceased's suicide was contributed to by the return to her of the item which she used as a ligature when it had been identified that, for her own safety, she should not have it in her possession."
5	**<u>CORONER'S CONCERNS</u>** 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) **(Addressed to Nightingales Care Limited and Zion Care Limited, referred to collectively as 'Nightingales')** Whereas the court heard evidence that Nightingales would not accept another patient with an equivalent medical profile/history and that, should a resident within one of Nightingales' homes require access to items to be restricted, they would be given 1:1 support pending a mental health assessment and discharge to a more appropriate facility, it was not possible for the home concerned to advise the court as to how and by whom the lead in question had been returned to Mrs Stringer. The concern arises that, in the case of a resident whose care *requires* access to items to be restricted, there should be a fail-safe, documented system, known to and implemented by staff, by which access to those items by the resident is prevented. In the circumstances that the possibility of a resident requiring such care may still arise, this concern exists notwithstanding the decisions now made. 2) **(Addressed to Nightingales Care Limited and Zion Care Limited, referred to collectively as 'Nightingales')** The court heard evidence as to the potential detrimental effects of isolation and loneliness in the elderly, including evidence from the court appointed expert that isolation can be very corrosive, that it is the single most potent causative risk factor for depression in the elderly and that it can have a very detrimental effect on a person's mental state. There is a need for this to be known amongst staff. The concern arises as one member of staff gave (disputed) evidence that they had little or no training in such matters. 3) **(Addressed to Lancashire and South Cumbria NHS Foundation Trust, Blackpool Teaching Hospitals NHS Foundation Trust, Lancashire County Council, Nightingales Care Limited and Zion Care Limited (the latter referred to collectively as 'Nightingales'))** The court heard evidence and/or found that a number of steps had not been taken pertaining to the transfer of information concerning Mrs Stringer's risk of suicide. They included the following: i. The care coordinator should have requested that the acute hospital make a referral to the Mental Health Liaison Team for a review; ii. It would have been good practice for a further professionals meeting / CPA review to have taken place prior to formal discharge and no later than just after discharge to Nightingales and for the family to have been invited, to ensure that everyone was aware of the plan, that the family was aware of Mrs Stringer's legal status and to discuss next steps in terms of liaison with other services; iii. There should have been greater professional curiosity and better communication at the time of transfer; iv. The Harbour mental health hospital's RNNA should have been reviewed to determine whether it needed to be updated and it should have been updated if there was any different clinical information. Further self harm or suicidal ideation, if seen to be significant, should have given rise to a further RNNA; v. There had, in fact, been further indications of self harm and suicidal ideation and, in any event, of a wish to die, on 30th June 2020, in August 2020 and on 3rd September 2020 which were significant and should have been addressed in the information provided to Nightingales and had not been; vi. Mrs Stringer was discharged from The Harbour mental health hospital without an up-to-date Care Act Assessment and, in any event, taking into account the need for Mrs Stringer to be transferred to the acute hospital (which had been necessary), an up-to-date Care Act Assessment had not been completed during the period of her admission to the latter hospital; vii. The risk assessment should have been completed and provided to Nightingales; viii. A positive behaviour support plan should have been completed and provided to Nightingales; ix. A care plan, compliant with CPA Policy and Procedures Key Standard 10, which should have identified

	a suitable environment in which to manage Mrs Stringer's risk, her needs and mental health and crisis and contingency planning, to cater for the event of a significant relapse in her mental health, should have been completed and provided to Nightingales; x. Risk behaviour should have been identified to Nightingales and context given, whereas that had not been the case in respect of certain behaviour, including the incident on 30th June 2020; xi. The care coordinator should have been better informed at the points of transfer and discharge; xii. There should have been more robust follow up by the care coordinator whilst Mrs Stringer was at the acute hospital; xiii. There had been no mental health service involvement between the 7-day follow up and 28th September 2020 or, if there had, it had not been recorded; xiv. During the COVID-19 pandemic, it was not possible for a manager to carry out a face-to-face assessment in the mental health hospital but no equivalent measure had been implemented; xv) Whereas it would have been helpful for Nightingales to have received the Continuing Healthcare Checklist, it had not been provided; xvi) Nightingales would have wished to see the risk of suicide referred to in the "Risks to the Service User" section of the FACE Overview Assessment; xvii) The court appointed expert had concerns about the accessibility of key information in the FACE Overview Assessment given the format of that document. Whereas the court heard evidence concerning subsequent, significant, purposeful, developments in practice, the matters listed above can be condensed into a single concern that there should be a *comprehensive, cohesive, frictionless* system for the timely collation (including from the family and/or other carers) and timely communication / transfer of *sufficient, accessible* information ((not, simply, risk assessments) pertaining to *suicide risk* in patients / service users / residents, by and between each of the service providers concerned.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you: **1) Lancashire and South Cumbria NHS Foundation Trust,** **2) Blackpool Teaching Hospitals NHS Foundation Trust,** **3) Lancashire County Council,** **4) Nightingales Care Limited and** **5) Zion Care Limited** 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 12th August 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: 1) The family of Margaret Florence Joyce Stringer 2) Lancashire and South Cumbria NHS Foundation Trust; 3) Blackpool Teaching Hospitals NHS Foundation Trust; 4) Lancashire County Council; 5) Nightingales Care Limited / Zion Care Limited. I am also under a duty to send the Chief Coroner a copy of your response. I may also send a copy of your response to any other 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	17/06/2022 Signature: *TR Holloway* (signed electronically) Tim Holloway Assistant Coroner **Blackpool & Fylde**