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 North West Ambulance Service NWAS** **2 Director of Public Health Prof.** [redacted] **3 Chief Constable** [redacted] **4 Police And Crime Commissioner** [redacted]
1	**CORONER** I am Andre REBELLO, Senior Coroner for the coroner 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 25 July 2022 I commenced an investigation into the death of Philip John BATTLE aged 73. The investigation concluded at the end of the inquest on 25 November 2022. The conclusion of the inquest was that: **Mr Battle died by suicide**
4	**CIRCUMSTANCES OF THE DEATH** Philip John Battle lived in warden supervised sheltered accommodation. On the 8th July 2022 he phoned the North West Ambulance service at 11.20. The call indicated an overdose and self-harm by hanging. From the triage protocol then in use this was graded as a category 3 response. This should have resulted in a response within 120 minutes. An ambulance arrived at his secure flat at 15.08 and found Mr Battle had died. He had a ligature around his neck [redacted]. He was certified as having died at 15.10. It remains unclear as to at what time Mr Battle died.
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) Evidence has been received that Philip Battle self-referred to the ambulance service stating he had taken and overdose and that he had tried to hang himself. The then triage system (medical priority dispatch) concentrated on questions relating to physical health such as his physiological function rather than assessing the actual presenting risks from poor mental health including self-inflicted fatal harm. Mr Battle lived in warden monitored sheltered accommodation and no inquiry was made about whether someone could be telephoned to check on his safety. Even if Mr Battle had not been in sheltered accommodation, it was unclear as to why there was no triage question about a phone number for a friend or relative. Evidence was given that NWAS work with Lancashire police and the health service

	in Blackpool with the Synergy project sharing the resources of a triage mental health car. These arrangements and relationships do not exist in Liverpool. The Court was concerned about silo - public health working between Blue light services - given the limited mental health intervention resource for NWAS was not on duty on the morning of 8th July and there was no call to Merseyside Police to see if its Mental Health triage car was available to intervene. Evidence was heard that these services need commissioning and there was no arrangement between Merseyside Police and the NWAS to share mental health intervention resources. This issue appears to become more important when the court heard of the plans for three mental health ambulances to be available in Merseyside and Cheshire in the near future. **The Court would like the ambulance service, Police and health providers to work together with the public funds at their respective disposal to develop in concert and to share community mental health crisis intervention resources for the good of the public.**
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 January 20, 2023. 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 **The family of Mr Battle** I have also sent it to the two main NHS mental health providers in Merseyside **Mersey care NHS Foundation Trust and the Cheshire and Wirral Partnership NHS Foundation Trust** who may find it useful or of interest. 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: 25/11/2022**

	[signature] **Andre REBELLO** **Senior Coroner for** **Liverpool and Wirral**