REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** (i) Bloomfield Medical Centre; (ii) Blackpool Teaching Hospitals NHS Foundation Trust; (iii) Lancashire and South Cumbria NHS Foundation Trust; (iv) North West Ambulance Service.
1	**CORONER** I am Timothy R Holloway, Assistant Coroner for the 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.
3	**INVESTIGATION and INQUEST** On 5 September 2019 an investigation was commenced into the death of Marlene McCabe. An inquest was opened on 10 September 2019. The investigation concluded at the end of the inquest held at Blackpool Town Hall on 6 March 2023 - 23 March 2023 and 3 May 2023. *Conclusion of Investigation (Section 4)* Unlawful killing. On 4th September 2019, between around 5.10pm and 5.50pm, Marlene McCabe was killed unlawfully in her own home. She died as a consequence of being struck a multiplicity of times to the head and face with a blunt object, namely, a doorstop, which occasioned catastrophic head and facial injuries. The actions of her assailant were more than minimally contributed to by the assailant's undiagnosed and untreated schizophrenia coupled with alcohol intoxication. Cause of death: 1 (a) Severe blunt force head and facial injuries.
4	**CIRCUMSTANCES OF THE DEATH** Box 3 of the Record of Inquest recorded as follows: On 4th September 2019, between around 5.10pm and 5.50pm, Marlene

	McCabe was killed unlawfully in her own home. She died as a consequence of being struck a multiplicity of times to the head and face with a blunt object, namely, a doorstop, which occasioned catastrophic head and facial injuries. The actions of her assailant were more than minimally contributed to by the assailant's undiagnosed and untreated schizophrenia coupled with alcohol intoxication. There were accepted prior failures in the collation and consideration of information, including from the available records and family, and in the mental health assessment of and progression of treatment for the assailant, in particular from early July 2019, which did not more than minimally contribute to Marlene McCabe's death.
5	**CORONER'S CONCERNS** 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: A. To: (i) Bloomfield Medical Centre (ii) Blackpool Teaching Hospitals NHS Foundation Trust (iii) Lancashire and South Cumbria NHS Foundation Trust 1) There remains the potential for a lack of understanding amongst clinicians as to how urgent referrals into the PIMHT should be made. B. To: (i) Bloomfield Medical Centre (ii) Blackpool Teaching Hospitals NHS Foundation Trust (iii) Lancashire and South Cumbria NHS Foundation Trust (iv) North West Ambulance Service 2) There is inconsistent availability of access to mental health records across the service providers and information sharing between service providers using different data bases is difficult. C. To: (i) Blackpool Teaching Hospitals NHS Foundation Trust (ii) Lancashire and South Cumbria NHS Foundation Trust 3) There is a residual risk that reference to drug and/or alcohol misuse in mental health referrals and/or assessments may lead

	to the missing of a mental health diagnosis and that circumstances may arise in which assumptions are made concerning substance misuse. D. To: (i) Bloomfield Medical Centre (ii) Blackpool Teaching Hospitals NHS Foundation Trust (iii) Lancashire and South Cumbria NHS Foundation Trust 4) There is a residual risk of non-communication of material information pertaining to patients' mental health between healthcare providers. E. To: (i) Blackpool Teaching Hospitals NHS Foundation Trust (ii) Lancashire and South Cumbria NHS Foundation Trust 5) There is a risk that delayed assessment of patients who may appear to be or are reported to be intoxicated will give rise to a loss of opportunity to identify signs of psychosis.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 7th August 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: (i) The family of Marlene McCabe (ii) [redacted], Bloomfield Medical Centre

	(iii) Chief Constable of Lancashire Constabulary 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	*TR Holloway* **Assistant Coroner for Blackpool & The Fylde** **Dated: 11th June 2023**