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:** **1.** Greater Manchester Mental Health NHS Foundation Trust
1	**CORONER** I am Kevin Mcloughlin, Assistant Coroner for the Coroner Area of Manchester West
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 the 9th February 2016 an investigation was commenced into the death of William Myers Lound, aged 30 years. The investigation concluded at the end of the inquest on the 19th January 2018. The conclusion of the inquest was that the deceased was unlawfully killed. The medical cause of death was: 1a) Multiple stab wounds.
4	**CIRCUMSTANCES OF THE DEATH** On the 7th February 2016 Mr Lound was killed by a man who had a long history of paranoid schizophrenia which had caused him to be compulsorily detained in high and medium secure psychiatric hospitals for many years before being released to supported accommodation in the community. This man pleaded guilty to the murder of Mr Lound and was subsequently sentenced to life imprisonment.
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: (1) The care and treatment provided to Mr Lound's attacker ("the attacker") in 2015/16 whilst in the community was fragmented, lacked continuity or an appropriate management strategy. Instead of being treated by the same team of psychiatric clinicians in 2015, he was admitted to four different psychiatric wards during 2015. The consultants involved in his

treatment did not confer sufficiently to produce a clear management plan.

(2) A variety of incidents should have alerted the clinicians and others involved in his management to the need for a multi-disciplinary case conference or a reassessment by an experienced Forensic Psychiatrist. Neither of these took place and in consequence warning signs of impending violence went unrecognised. Examples included being found by the Police in a public place in possession of a bladed article whilst under the influence of some substance and admitting he was hearing voices commanding him to kill people.

(3) Valuable background information was not circulated to those involved in the attacker's treatment with the result that they were deprived of the crucially important medical history that would have signposted the potential risks (particularly if the attacker was no longer taking the medication which controlled his schizophrenia and had once again resorted to using illicit drugs). An example of this concerns a 20 page Discharge Report prepared in January 2013 by a Consultant Forensic Psychiatrist at the time the attacker was being prepared to leave Ashworth High Security Psychiatric Hospital. This was not seen at the material time by the Care Coordinator, the GP nor the Consultant Psychiatrists who undertook treatment on two different psychiatric wards and in the community.

(4) On three occasions during 2015 other clinicians who encountered the attacker recommended that a Mental Health Act assessment be considered with a view to the attacker being sectioned. These recommendations were not acted upon. Judgements were made by Consultant Psychiatrists that the attacker was not detainable. These judgements merited a second opinion at the least, preferably by a Forensic Psychiatrist. Had the issues been evaluated with the benefit of the forensic history, the attacker's propensity to violent conduct may well have triggered a Mental Health Act Assessment.

(5) Gaps in record keeping hindered the coordination of treatment. Examples included a void in the medical notes to explain why the murderer had been transferred from one acute psychiatric ward to another (with a different consultant and clinical team), a discharge in his absence taking place on 8th October 2015 without any record of a risk assessment having been produced or a plan as to how he was to be followed up and who was to be notified, nor an explanation as to who had authorised the 'discharge in absence' and why this was done.

Overall, the lingering concern is that complex cases such as this are not identified early enough and managed by an identified and appropriately qualified Psychiatrist whose responsibilities should include the coordination of all the clinicians and agencies involved, by way of periodic case conferences with reasons for decisions made being recorded and circulated.

The scarcity of inpatient psychiatric beds fuels the concern that complex individuals are being treated in the community rather than controlling the risks

	they present by having them remain in hospital until such time as their condition has been shown to have stabilised.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and 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 19th March 2018. 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 and others: 1) [redacted] 2) Manchester Health and Care Commissioning 3) Greater Manchester Police ([redacted]) 4) NHS England 5) [redacted] GP at Ashfield Surgery 6) The Secretary of State for the Department of Health 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	**Dated** **19th January 2018**
	Signed **HM Assistant Coroner, Mr Kevin McLoughlin**