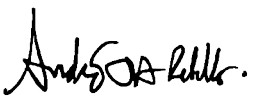
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (2)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Mersey Care NHS Foundation Trust** 2a Oakhouse Park, Liverpool L9 1EP 2. **The family of Sarah –Louise** 3. **Merseyside Police** 4. **The Chief Coroner**
1	**CORONER** I am Andre REBELLO, Coroner for the area of Liverpool & 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** On 04/03/2022 I commenced an investigation into the death of Sarah-Louise Jennifer Doyle, aged 19. The investigation has not yet concluded and the inquest has not yet been heard.
4	**CIRCUMSTANCES OF THE DEATH** Sarah Louise Doyle was 19 years old with a history of emotionally unstable personality disorder and anorexia personal eating disorder. She was detained under Section3 MHA. She had been a patient on Harrington ward since 15th November 2021 and was moved to Clock View, Alt Ward on 16th December 2021. On Saturday 26th February 2022 at 21.00pm a support worker took over responsibility for completing checks on patients as a result of their risk assessment. Sarah was on 5-minute observations due to a risk of ligaturing. During the 5 minute checks on there were no incidents of note. At 21:25pm the support worker went into Sarah's room where she was sat on the bed, replied she was ok when asked and support worker left the room and closed the door. On checking at 21:30pm support worker could not see her sat on her bed so went into her and found Sarah hanging [redacted]. [redacted] The support worker ran out of the room and requested assistance from colleagues who managed to remove ligature and commence CPR until paramedics arrived and took over. She was taken to Aintree Hospital and sadly despite best efforts her death was pronounced at 01.40am 27th February 2022. An article 2 investigation has been commenced and the Forensic postmortem result from the 3rd March 2022 is awaited pending special examination including toxicology.
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 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. – On a review of the five minute observations these were recorded exactly on each five minutes after the hour – 05, 10, 15, 20 etc. It will be a matter for evidence to be heard at the inquest whether these times were precise or whether they were written in anticipation of future observations. The observations were covered by one signature with a downward arrow. In other settings it is better practice for five minute observations to be 12 frequent but unpredictable observations within each hour – to minimise the risk of a self-harm attempt being planned from the timing of previous observations.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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 29/04/2022. 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 Sarah-Louise's mother and Merseyside police. 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	**[DATE]** **[SIGNED BY CORONER]**  **04/03/2022**