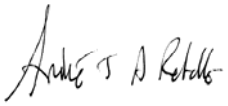
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **(Chair)** **Wirral Clinical Commissioning Group** **Pld Market House** **Hamilton Street** **Birkenhead** **Wirral** **CH41 5AL** With regard to concern 1 [redacted] **Perinatal Mental Health** **Clinical Reference Group** **NHS England** **PO Box 16738** **Redditch** **B97 9PT** With regard to concern 2 **Rht Hon Jeremy Hunt MP** **Department of Health** **Richmond House** **79 Whitehall** **London** **SW1A 2NS** With regard to concerns 1 & 2
1	**CORONER** I am André J A Rebello OBE, Senior Coroner, for the area of 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 10th December 2012 I commenced an investigation into the death of **Samarjit Natasha SINGH**, Aged **33**. The investigation concluded at the end of the inquest on 23 May 2014. The conclusion of the inquest was Ia Hypoxic Brain Injury Ib Hanging On 21st September 2012, Samarjit Natasha Singh gave birth to her son. Following his birth, she suffered from post natal depression, which resulted in an act of deliberate self

	harm on 6th October 2012 and a threat of self harm on 8th October 2012. On 4th December 2012, at about 12.30 p.m., Samarjit Natasha Singh was found with a ligature fashioned from an unwound turban around her neck, attached to the banister above, at [redacted] Bromborough in the Wirral. She was in cardiac arrest and, following advanced life support, cardiac output was restored but not before she sustained an irreversible hypoxic brain injury. She was certified as having died at 2.14 p.m. the following day in hospital. It is unclear as to whether the deliberate self harm acts were with the intention of causing death but it is clear that these acts were linked with the state of her mental health.
4	**CIRCUMSTANCES OF THE DEATH** On 21st September 2012, Samarjit Natasha Singh gave birth to her son. Following his birth, she suffered from post natal depression, which resulted in an act of deliberate self harm on 6th October 2012 and a threat of self harm on 8th October 2012. On 4th December 2012, at about 12.30 p.m., Samarjit Natasha Singh was found with a ligature fashioned from an unwound turban around her neck, attached to the banister above, at [redacted] Bromborough in the Wirral. She was in cardiac arrest and, following advanced life support, cardiac output was restored but not before she sustained an irreversible hypoxic brain injury. She was certified as having died at 2.14 p.m. the following day in Arrowe Park hospital. It is unclear as to whether the deliberate self harm acts were with the intention of causing death but it is clear that these acts were linked with the state of her mental health.
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. – Mrs Singh suffered from severe postnatal depression following the birth of her son. Clearly she needed to be with her son whilst she was being treated for her perinatal mental health issues, given his needs. 1. There was no Specialist Community Perinatal Mental Health Service in the Wirral to meet both her son's and her needs. The treatment that was available was sub-optimal. 2. There is not a Mother and Baby Perinatal Mental health in–patient Unit in the Liverpool City Region serving the needs of Lancashire, Merseyside and East Cheshire. 50% of referrals from this area to the Manchester Unit decline because it is too far from family and support networks but more relevantly from older sibling children who remain in the family home
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 **21st July 2014**. 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 [redacted] (husband), [redacted] (father) and [redacted] Consultant Psychiatrist, Cheshire Wirral Partnership 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	 **André Rebello** **Senior Coroner for the** **City of Liverpool** **Dated: 23rd May 2014**