	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** The Chief Executive, Pennine Care NHS Foundation Trust **2.** [redacted], Director of Commissioning/Lead for Mental Health, Rochdale, Heywood and Middleton Clinical Commissioning Group (RHM CCG)
1	**CORONER** I am Ms L J Hashmi, Area Coroner for the Coroner area of Greater Manchester North.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 15th February 2016 commenced an investigation into the death of **Susan Beverley George.**
4	**CIRCUMSTANCES OF DEATH** The deceased had suffered from long standing mental health problems, including depression, anxiety, dysthymia and obsessive compulsive disorder (OCD) traits and was known to both the community and inpatient mental health services. She was admitted to the acute mental health unit, as a voluntary patient, on the 9th October 2014 and was subsequently allowed to take self-discharge on the 31st October 2014. Later the same day she contacted her GP surgery in an acutely anxious state. She was prescribed a sedative and allowed home in the company of a friend. On the 1st November 2014, Ms George presented to the Emergency Room at Fairfield General Hospital, again in a heightened state of anxiety and at risk of self-harm, having been found by members of the public wandering around Healey Dell looking for a viaduct to jump from. The deceased was assessed by the RAID Practitioner. Voluntary admission was offered but declined, by reason of Ms George's pre-existing condition (OCD). Admission to an alternative unit was not offered. The deceased was deemed to have mental capacity. No consideration was given to assessment for compulsory detention under the provisions of the Mental Health Act. Ms George was allowed home with community follow-up.

On the 2nd November 2014, the deceased contacted the Home Treatment Team and was subsequently admitted to the mental health unit as a voluntary patient.

Discharge had originally been scheduled to take place on the 7th November 2014 but due to Ms George's levels of anxiety, was deferred by agreement until after the weekend.

On the 10th November 2014 discharge went ahead despite:
- the deceased's fears about keeping herself safe
- cause for concern raised by friends
&
-calls made by Ms George to the Access and Crisis Team and Greater Manchester Police emergency service ('999').

The ward nursing and medical teams were aware of the deceased's reluctance to be discharged and some, but not all, were aware of the telephone calls that had been made.

The 'Discharge Pad' identified that the deceased was feeling suicidal and showed that the friend who collected her had expressed concern that Susan may take all her medication at once.

The deceased arrived home at shortly after 21:00 hours on the 10th November. At some time after 09:00 on the 11th November 2014 she left her home address, making her way to Healey Dell where she subsequently ingested an excessive quantity of prescribed medication, with fatal consequences. She was found deceased in undergrowth at Healey Dell on the morning of the 12th November 2014.

Susan George died as a result of a misadventure contributed to by neglect.

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:-

Pennine Care NHS Foundation Trust:

1. No review of the decision to discharge was sought or conducted when it became apparent that there had been a material change in Susan's presentation on the 10th November. Had a review taken place then it is likely that the discharge would have been deferred or cancelled.

	2. The discharge process was disjointed, lacked co-ordination and did not involve Susan's Primary/Associate Nurse. 3. The Discharge Policy was perfunctory and staff failed to follow it in any event. 4. Poor record keeping, predominantly on the part of the nursing staff. 5. There is no protocol/guidance on what steps should be taken when an inpatient contacts the emergency services (e.g. police via 999). This is important as it goes to risk assessment/management. 6. Unprofessional staff attitudes towards patient/care provision – two qualified nurses involved in Susan's care used inappropriate language and demonstrated negative ways of thinking during both conversations with colleagues and the police communications operator. Prevailing attitudes such as this, particularly towards vulnerable adult, puts care standards at risk. 7. Poor advocacy on the part of the nursing staff whose decisions appear to have been clouded by the rigidity of the medical decision to discharge. 8. Staff were unaware of how to support and advise patients on the issue of obtaining a second medical opinion where the patient disagrees with the first doctor's decision (in this case, to proceed to discharge). **<u>Pennine Care and the RMH CCG:</u>** 9. There is no inpatient Clinical Psychologist service available within Pennine Care. This is the second (possibly third) PFD Form on the same issue. The Trust maintains that this is as a result of commissioning issues. Without inpatient clinical psychology, there is a marked service gap that puts patients such as Susan at risk.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 the **<u>25th April 2016</u>**. 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 namely:- The deceased's family Greater Manchester Police Nursing & Midwifery Council CQC

	NHS England 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 from. 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: 29th February 2016 Signed: L J Hashmi