REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Chief Executive of Greater Manchester West Mental Health NHS Trust**
1	**CORONER** I am Anna Morris, Assistant coroner, for the coroner area of South Manchester
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 25th April 2016 I commenced an investigation into the death of Rachel Morgan. The investigation concluded on the 9th February 2017 and the conclusion reached by the Jury was one of **Suicide with an appended Narrative.** The medical cause of death was 1a) Severe anoxic brain injury.
4	**CIRCUMSTANCES OF THE DEATH** **Prior to the birth of her second baby, Rachel was healthy, did not like taking medication and had no previous mental health issues. After the birth she became increasingly unwell with fluctuating moods and emotions, which led to her seeking medical help. She made two suicide attempts, after which she was admitted to hospital. After each admission she was discharged under the care of home-based community teams. She was diagnosed with post-natal depression with psychotic symptoms, which gradually worsened, with some fluctuations. Rachel had fears of harm coming to her baby but became increasingly detached from her, though there was no concern that she was a threat to her children. The mother and baby unit was discussed on several occasions with one referral put on hold awaiting a multi-disciplinary team meeting. Immediately prior to her admission in April, her partner and mother did not feel they could keep her safe in the community. Rachel attended an outpatient's appointment on the 12th April to review her medications. During this appointment, the clinician's ongoing concerns were heightened by the knowledge that she had been ordering drugs on the internet to end her life. Rachel did not want to be admitted to hospital so went home, where she was restrained until professionals arrived. She was taken to hospital under an emergency section 4 of the mental health act due to the unavailability of a second opinion doctor at that time. The approved mental health professional provided a verbal handover to the ward staff, highlighting Rachel's history and her current high risk. There were contradictory accounts of the content of the handover and there were possible omissions in the handover which were not fully documented. Rachel was admitted to the ward by a section 12 doctor, observed by the clerking doctor. A risk assessment was completed by nursing staff who initially put her on amber risk of suicide, which was updated to red soon thereafter. She was put on level three observations and allocated a primary nurse who was on nights. During her time on the ward, she was assessed to be engaging and talking to staff but had constant thoughts to end her life. Concerns were raised by nursing staff about her preoccupation with a Nicorette inhalator, concerns which were recorded on the PARIS system but were not included in an updated risk assessment. They were not shared with doctors prior to the ward round. On the 15th April the family highlighted specific concerns regarding Rachel's safety which were discussed by nursing staff, updated on the PARIS records but were not added to the risk assessment. The levels of observation were not raised. Despite Rachel's and her family's repeated requests to review and change her medication, this was continually delayed and no immediate action was taken. Rachel was found at approximately 10.20am on 16th April 2016 in room 7 of the Medlock ward, Moorside unit.**

	Four nurses attempted to open the door to Rachel's room, one of whom entered to find Rachel slumped behind the door with a ligature around her neck. A crash team and ambulance staff were called and CPR was commenced. Rachel was transferred to Salford Royal Hospital at approximately 11.20am and died from severe anoxic brain injury on 24th April 2016. The Jury concluded that Rachel died as a result of suicide and recorded the following narrative conclusion: **Suicide and Narrative: The level of observations on the day Rachel was admitted were insufficient. The Trust has accepted that on 12th April the level of observations should have been considered on admission and a decision to place Rachel on enhanced observations would not have been unreasonable. The information relating to Rachel's conversation with the nurse on 14th April regarding the Nicorette inhalator should have been handed over to the clinicians conducting the ward round on 15th April. It is possible that had this information been available, the clinician may have altered the level of observations. The information from [redacted] during her telephone call to the Medlock ward on the evening of 15th April should have led to a change in Rachel's level of observations. We consider that level 1 would have been appropriate. The failure to put Rachel on level 1 observations probably contributed to her death, as it provided her with the opportunity to end her life. The trust accepts that on the 15th April 2016 staff could have considered level 2 observations as a minimum, following Rachel's mother telephoning the ward with her concerns. The Trust also accepts that the risk assessment documentation should have been updated to include the new information provided by Rachel's mother; the discussion which took place with Rachel and the reasons for the staff not increasing levels of observations. It is more than likely that the delay in reviewing Rachel's medication contributed to her increased hopelessness and risk of suicide.**
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) I am concerned that despite the fact that Rachel Morgan and her family made it clear to the staff at the Medlock Ward from the start of her admission that she wanted her medication to be reviewed as felt that her anti-depressant medication was not working, no steps were taken to begin the review process during the 4 days she was an inpatient before her death. I am concerned that in the knowledge that Rachel was reporting issues with her medication, a medication summary could have been undertaken before the first ward round took place on the 15th April. Please consider whether on admission patients should have a medication summary completed as part of the clerking process, which would allow any medication reviews to be conducted by an appropriate Doctor at the first available opportunity. (2) I am concerned that on 2 occasions matters came to the attention of the nursing staff that gave them cause for concern regarding Rachel's risk of self-harm/ suicide and that neither of these incidents generated a full risk assessment to be conducted. Those incidents were the incident with the Nicorette Inhalator on the 14th April 2016 and the phone call from Rachel's mother on the 15th April 2016. (3) I am concerned that on 2 occasions that observations were considered and/or reviewed were conducted, they were not reviewed by a multi-disciplinary team as per Paragraph 5.4 of the GMWMHT Observation Policy 2012. Those

	occasions were on the 12th April 2016 and 15th April 2016 (evening). Please consider further training of all members of staff in relation to the need to engage in a specific risk assessment review process with a multi-disciplinary forum following incidents that raise issues in relation to suicide and self –harm (4) I am concerned that there is a lack of clarity around the different levels of observations contained within the GMWMHT Observation Policy 2012. In particular, I draw your attention to the conclusions of the SIR Section 7 Paragraph 8 in which the authors state that "the review team recommend that consideration is to be given by Integrated Governance as to whether there needs to be a statement added to the policy to indicate that intermittent observations can be used for an assessed risk (that is not imminent) or whether the policy provides sufficient clarity in this respect. (5) As the Serious Incident Review highlighted, I am also concerned that staff at the Medlock Ward placed an over-reliance on the fact that Rachel was an inpatient as being a protective factor. The evidence I have heard confirms the findings of the SIR that during her time on the Medlock Ward Rachel's feelings of hopelessness and constant thoughts of self-harm did not reduce during her time and although her means for ending her own life were reduced, they were not entirely removed. There was evidence available to nursing staff that could indicated that Rachel was still thinking about ending her life whilst an inpatient and was considering the means that would allow her to do so. The jury have found that this was not adequately addressed by implementing enhanced observations.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 10th April 2017. 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 [redacted] who may find it useful or of interest. 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	**Anna Morris** **Assistant Coroner**