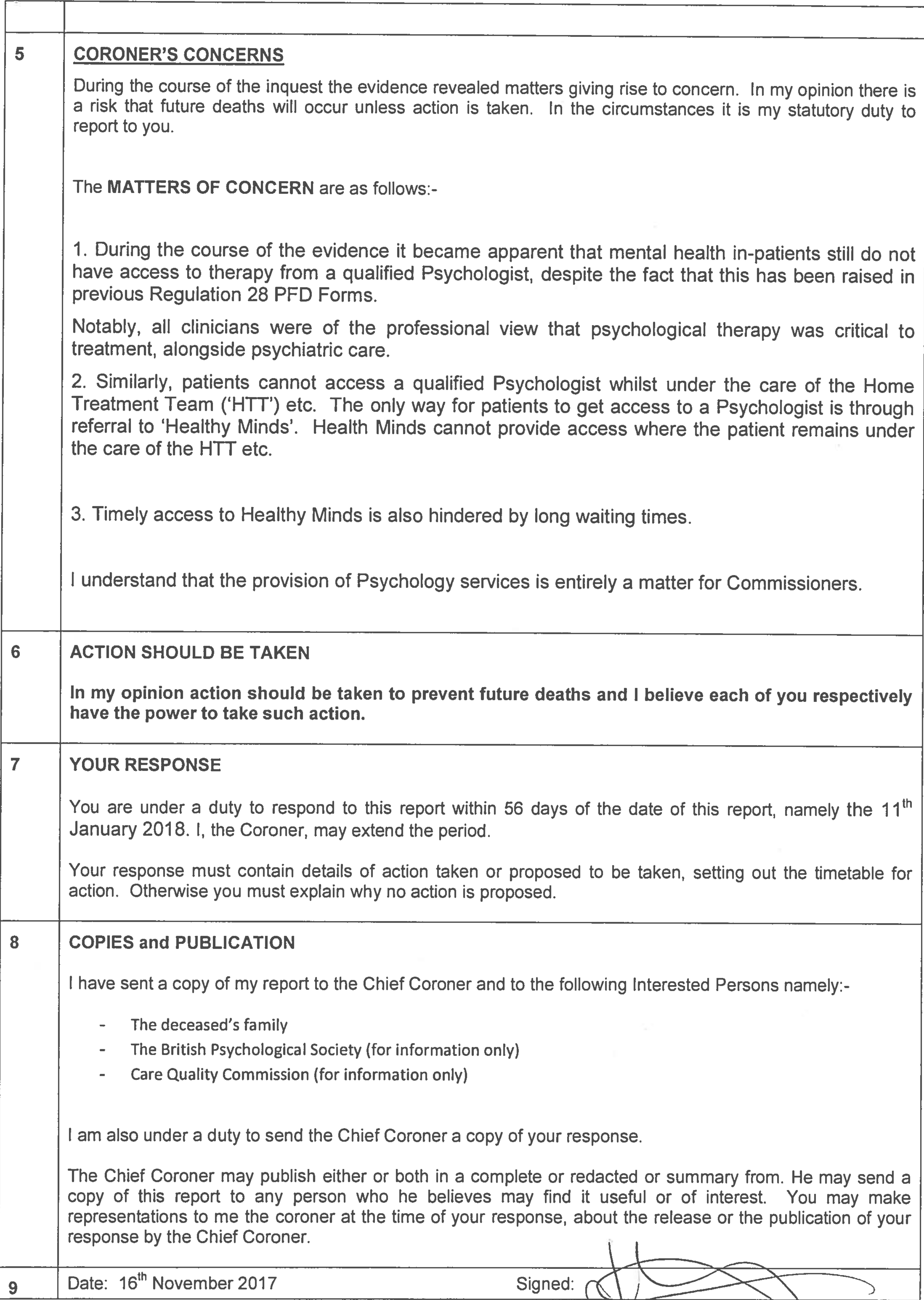
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Department of Health, London 2. NHS England, Manchester 3. Chief Executives of Bury, Rochdale and Oldham Clinical Commissioning Groups 4. Chief Executive, Pennine Care NHS Foundation Trust
1	**CORONER** I am Ms L Hashmi, Area Coroner for the Coroner area of 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 21st June 2017, I commenced an investigation into the death of **John Haines.**
4	**CIRCUMSTANCES OF DEATH** Against a backdrop of a sudden and unexplained onset of anxiety and depression in December 2016, the deceased had been under the care of the community mental health team/Home Treatment Team and his GP until the 17th March 2017, whereupon his mental health had deteriorated to such a degree that he could no longer be safely managed within the community. He was therefore admitted to a mental health ward as a voluntary in-patient. He was diagnosed with and treated for anxiety and depression. During the course of this admission he was seen by three different Consultants, the last of which opined that he was suffering from a psychotic episode and delusional thoughts. Whilst earlier identification of this symptomatology may have resulted in the revision and implementation of different treatment sooner, it would not have materially altered the outcome. Following medication review by the third Consultant, the deceased's condition improved and after a successful period of home leave, he was discharged on the 14th June 2017 with planned follow-up by the Home Treatment Team and Early Intervention Team. On the 15th June 2017 the Home Treatment Team contacted the deceased by telephone and arrangements were made to visit him. When the team attended as planned on the 17th June 2017, there was no answer at the deceased's home address. Family subsequently tried to contact the deceased, to no avail. A concern for welfare was raised. Police attended and forced entry. The deceased was found in his bedroom. The fact of his death was confirmed by attending Paramedics at around 19:18 hours the same day. The thrust of the evidence suggested that the deceased had been actively making plans to end his life prior to discharge from hospital, despite reassurances to the contrary. The mechanism used was in keeping with this and the circumstances in which the deceased was found.



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. During the course of the evidence it became apparent that mental health in-patients still do not have access to therapy from a qualified Psychologist, despite the fact that this has been raised in previous Regulation 28 PFD Forms.

Notably, all clinicians were of the professional view that psychological therapy was critical to treatment, alongside psychiatric care.

2. Similarly, patients cannot access a qualified Psychologist whilst under the care of the Home Treatment Team ('HTT') etc. The only way for patients to get access to a Psychologist is through referral to 'Healthy Minds'. Health Minds cannot provide access where the patient remains under the care of the HTT etc.

3. Timely access to Healthy Minds is also hindered by long waiting times.

I understand that the provision of Psychology services is entirely a matter for Commissioners.

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 11th January 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 namely:-

- The deceased's family
- The British Psychological Society (for information only)
- Care Quality Commission (for information only)

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: 16th November 2017 Signed: