REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Executive of Pennine Care NHS Foundation Trust
1	**CORONER** I am Catherine McKenna, 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 16 June 2019, I commenced an investigation into the death of **Sean Robert Steven Owen (dob: 23 07 1965).** The investigation concluded at the end of the inquest on 23 October 2020. The inquest determined that the medical cause of death was 1a) pneumonia 2) hypoxic ischaemic encephalopathy secondary to cardiac arrest secondary to penetrating neck injury. I returned the following Narrative Conclusion: Against a background of paranoid schizophrenia, the Deceased died by means of a self-inflicted penetrating injury to his neck using a serrated knife at a time when he was experiencing psychotic symptoms. He was under the care of the Community Mental Health Team at the time of his death and it was recognised that he posed a significant risk to himself when non-compliant with medication. The arrangements in place for monitoring his medication compliance and managing the risks posed when he became unwell were inadequate. Whilst the evidence does not show to the required standard that those failures caused or contributed to his death, it is possible that his death would have been averted had more robust care arrangements been in place.
4	**CIRCUMSTANCES OF DEATH** The Deceased had a long-standing history of paranoid schizophrenia which was treatment resistant. From 2014, he had been maintained in the community through depot medication. In October 2018, he refused to accept the depot injection and was switched to oral medication. He became non-compliant with his medication and following an overdose was admitted to Hollingworth Ward at Birch Hill Hospital under section 2 of the Mental Health Act 1983 on 6 December 2018. The section 2 was rescinded on 31 December 2018 and during January 2019 there were two episodes when the Deceased took overdoses and evidence that he continued to express thoughts of wanting to end his own life. He was discharged from Hollingworth ward on 6 February 2019. He was recognised as a significant risk to himself if he became non-compliant with medication. The discharge package set up to monitor his compliance with medication had broken down by 21 February 2019 and after that date, his compliance was not monitored. The Deceased was not seen in Outpatient clinic and cancelled the appointments arranged for him on 28 February, 8 April and 2 May 2019. The monthly contact with his care co-ordinator was insufficient in view of the risks of his non-compliance. On 30 May 2019, the Deceased's sister alerted the care coordinator to the Deceased's deteriorating mental state and the Deceased agreed to meet with a psychiatrist. A request for an appointment to take place within 3 to 7 days was faxed to the Community Mental Health Team office.

	On 3 June 2019, the Deceased barricaded himself in his own home and severed his jugular vein using a serrated knife. He was taken to Manchester Royal Infirmary and suffered a cardiac arrest en route. He had suffered a hypoxic brain injury and died as a result of his injuries and a chest infection on 14 June 2019.
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:- I heard evidence that there is currently no system in place at Pennine Care NHS Foundation Trust for quality assurance of the Discharge Summary Letters which are sent to General Practitioners when a patient is discharged from in-patient care. The evidence heard at the inquest and recorded in the clinical records was that Mr Owen's admission to Hollingworth Ward on 6 December 2018 had been precipitated by an overdose; that there were two further incidents of overdose during the admission; that he was changeable in relation to risk, sometimes stating that he wanted to end his own life and at other times denying it and that he presented a significant risk to himself and others if he became non-compliant with medication. The Discharge Letter that was sent to Mr Owen's GP on 6 February 2019 was prepared by a doctor who had little involvement in his care and was not counter-checked by a senior clinician. It omitted references to the overdoses and was erroneous in stating that there had been 'no issues or incidents' during the admission; that the Deceased 'never showed any DSH behaviour as an inpatient' and that 'we did not see any SH behaviour or expressed thought from Sean during his admission.' The letter made no reference to the significant risk associated with non-compliance.
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 21 December 2020. I, the Area 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] (sister of the Deceased) 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: 23 October 2020 Signed: