ANNEX A

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:** **1. Chief Executive, Greater Manchester Mental Health NHS Foundation Trust**
1	**CORONER** I am Adrian Farrow, assistant coroner, for the coroner area of Manchester South
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 12th August 2019 an investigation was commenced into the death of Saima Hussain – also known as Saima Hussain Mann, aged 40 years. The investigation concluded at the end of the inquest on 1st April 2021. The conclusion of the inquest was that she died of suicide by hanging.

4	**CIRCUMSTANCES OF THE DEATH** The inquest heard that Saima Hussain had a long history of mental disturbance. For the 12 months preceding her death on 10th August 2019, she had assistance from the Psychological Therapies Service, which concluded at the end of January 2019, followed by repeated episodes of crisis. She was an in-patient under s2 Mental Health Act 1983 at the beginning of April 2019 and again at the beginning of May 2019. There were a number of mental health assessments undertaken during this period, none of which identified any risk of harm to herself. The Community Mental Health and the Trafford Adult Social Care teams were both involved and she was the subject of discussion at multi-disciplinary and Daily Risk meetings. She had contact with her GP. Ms Hussain was assessed by a Clinical Psychiatrist, who concluded that she did not meet the criteria for assistance by the Community Mental Health Team and an informal referral was made back to the therapist at the Psychological Therapies Service who had assisted her previously. That informal referral was subsequently formalised. The inquest heard that Ms Hussain relied upon particular healthcare professionals in whom she had established confidence and trust. Once the referral had been accepted, there was no identifiable person who could be a point of contact for Ms Hussain. At the time of the handover from the Community Mental Health Team to the Psychological Therapies Service, the inquest heard that Ms Hussain told the social worker from the Community Mental Health Team that she felt “lost” and “abandoned”. The Psychological Therapies Services attempted to send an acknowledgement letter to Ms Hussain, which was returned undelivered. It was pro-forma in nature and gave no indication as to the likely course of events beyond the fact that she had been placed on a waiting list. There was no direct contact with Ms Hussain between her discharge from the Community Mental Health Team and her death to inform her of the plan for her future care and the evidence was that she experienced a further period of crisis which appears to have been triggered by the lack of contact and information surrounding her referral to the

	Psychological Therapies Services. Ms Hussain took her own life in early August 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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – The Trust had systems and procedures in place in relation to the referral by the Community Mental Health Team to the Psychological Therapies Services, but there did not appear to be in a place a reliable or established system which would ensure that the service-user would receive direct contact from the Trust, tailored to their particular situation and condition to ensure that they were fully informed as to the fact, status and plan for their referral. The acknowledgement letter which was intended to be delivered to Ms Hussain was a pro-forma which gave no indication as to what she should expect, beyond the information that she had been placed on a waiting list. It does not appear that the procedures in place take account of the likely needs of the service-users who are by definition, seeking assistance with mental illness. It is understood that the Community Transformation Project is currently in the process of reviewing the mental health service, but there is no timescale available over which the question of referrals will be considered. Pending that review, my concern is that the level and method of communication with those being referred to the service does not take account of their particular needs and may affect their mental health.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 10th June 2021. 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] (family of deceased), and [redacted] (family of deceased). I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**15th April 2021**  **Signature:** **Adrian Farrow, Assistant Coroner, Manchester South**