REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Executive Medical Director, 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 28 August 2020 I commenced an investigation into the death of Angela Marie FROST. The investigation concluded at the end of the inquest on 21 May 2021. The medical cause of death was (1a) Amitriptyline Overdose. The conclusion of the inquest was 'suicide whilst the balance of her mind was disturbed.'
4	**CIRCUMSTANCES OF DEATH** The Deceased was admitted to Aspen Ward, Royal Oldham Hospital on 8 June 2020 following a mixed overdose. She complained of sensations which included feeling that her insides 'melting,' that she had 'hot lava' and 'snakes in her stomach' and 'a brain haemorrhage causing trickling in her head.' Hormonal tests undertaken during the admission established that the Deceased was post-menopausal. The Consultant Psychiatrist with responsibility for the Deceased was of the opinion that the sensations where related to the menopause rather than a psychosis. A GP trainee spoke to a Gynaecology Registrar who advised that HRT was contraindicated and recommended the use of herbal alternatives. The Deceased declined to take the herbal alternative and was discharged from the ward on 2 July 2020 on anti-psychotic medication. The Consultant Psychiatrist recommendation that a referral be made by primary care to Gynaecology to discuss HRT alternatives was not communicated to the Deceased's GP. On 21 July 2020, the Deceased was re-admitted to Aspen Ward after being located in woodland. She had been missing for 7 days with the express intention that she starve herself to death. During her second admission, her anti-psychotic medication was increased. The Consultant Psychiatrist formulated a diagnosis of 'profound menopause with secondary kinaesthetic hallucinatory experiences.' These diagnosis does not feature in ICD-10 and a second opinion was not requested or obtained by the Consultant Psychiatrist. No contact was made with the Specialist Pharmacist attached to the locality to establish whether HRT was contraindicated and no further contact was made with the Gynaecology team. Had enquiries been made with the pharmacy team, it is more likely than not that it would have established that HRT was not absolutely contraindicated and therefore would have been a potential treatment option. The Deceased's family members were not involved in discussions around all available treatment options and despite leaving messages for the Consultant Psychiatrist to contact them, sufficient enquiries were not made as to whether the Deceased consented to their involvement in her care. It is more likely than not that had sufficient enquiries been made, the Deceased would have consented to sharing information with her family which would have provided her with a source of support in her decision-making. The Deceased took her own discharge from the ward on 7 August 2020. A table-top review meeting was held on the same day in which the Early Intervention Team were updated on the Deceased's condition. The Deceased was last seen by a mental health professional on 20 August 2020 during which she described an improvement in her symptoms. She was found deceased at her home address on 24 August 2020 having taken an intentional overdose of her partner's old medication.

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) There is no formal guidance or process in place at the Trust for Consultant Psychiatrists to seek a second opinion in relation to diagnosis, treatment plans or whether a patient meets the criteria for detention under the Mental Health Act. The evidence was that whilst there is nothing to prohibit a Consultant requesting a second opinion, it rarely happens in practice. (2) There is no formal guidance or process in place at the Trust for health care professionals or family members to seek a second opinion in relation to the matters set out above. (3) The court heard evidence that there is a lack of understanding on the part of in-patient Consultants as to rules around confidentiality and the nature/extent of permissible communication with family members ie: the difference between receiving information which might inform diagnosis, treatment and risk planning and discussions which involve sharing confidential health information.
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 **23 July 2021**. 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] • I have also sent a copy to the Care Quality Commission 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 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.
	Date: 28 May 2021 Signed: