Derby & Derbyshire Coroner's Area

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Linden Medical Group, Stapleford Care Centre, Church Street, Stapleford, Nottingham NG9 8DA** **2. NHS Nottingham and Nottinghamshire Clinical Commissioning Group, 1Standard Court, Park Row, Nottingham, NG1 6GN**
1	**CORONER** I am **Peter Nieto**, Area Coroner, for the Coroner Area of **Derby & Derbyshire**
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** I commenced my investigation into the death of Hazel Ann Binks on 19 January 2021 and opened an inquest on 17 February 2021. The inquest concluded on 22 June 2021 at the Derby Coroner's Court, St Katherine's House, St Mary's Wharf, Mansfield Road, Derby. My conclusion at inquest was 'suicide'.
4	**CIRCUMSTANCES OF THE DEATH** Hazel Binks died at her son and daughter-in-law's house on 14 January 2021 due to lack of oxygen caused by her placing a fastened plastic bag over her head. Hazel had become concerned that she was suffering from a sexually transmitted disease due to various symptoms she had although up to her death there was no evidence that this was the case. There is reason to consider that there was a degree of irrationality to her belief, particularly as Hazel referenced an event many many years previously as being the cause. On 10 January Hazel had made preparations to asphyxiate herself with a plastic bag and wrote a farewell note. Her family became aware and it was arranged for her to stay with them to try and keep her safe. On 11 January Hazel had a GP consultation to discuss her physical symptoms. Her daughter-in law was with her and raised concerns that Hazel had suicidal thoughts. Hazel explained this as her 'getting into a state' and the GP did not ask any probing questions as to the details, intent, or her current thoughts. Hazel was given mental

health helpline and self-referral information, advice if there was an emergency, and was asked to book a two week follow up GP appointment. On the evening before her death Hazel did not express any suicidal thoughts and did not raise any immediate concerns for her family.

On the evidence and on the balance of probabilities Hazel undertook a deliberate act with the intention of taking her own life given the nature of the act, the previous preparations on 10 January, the content of the two notes she left which read as farewell notes, and her likely state of mind.

NB - The above summary is taken from the Record of Inquest. By way of further detailed information in relation to this report: -

- The daughter who was with Hazel during the GP consultation rang the GP surgery just prior to the consultation to express her concern that Hazel had suicidal thoughts. On the evidence of the GP, Dr [redacted], the practice admin had passed her a note of the call but there was no mention of anything relating to suicide.

- During the consultation Hazel's daughter-in-law told the GP that hazel was suicidal and had made plans. With reference to suicide Hazel appears to have explained herself as 'getting into a state' and was then very focussed on physical symptom concerns. In evidence Dr [redacted] stated tat she wanted to focus on progressing further physical health assessments as Hazel's worries about her physical health appeared to be driving her anxiety. Dr [redacted] did not elicit any details of suicidal plans (which would have been likely to have drawn out the details of the preparations for self-asphyxiation on 10 January and writing of a 'farewell note'), did not examine issues of intent, current risk, or undertake any meaningful mental health examination. In evidence Dr [redacted] stated that had she been in possession of all the relevant information she would have had discussion with the mental health crisis team for its advice and possible input.

5 **CORONER'S CONCERNS**

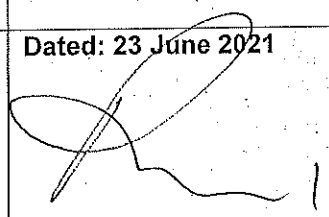
During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

(1) The GP practice admin did not pass on the concerns of suicidal thoughts to the GP. This was clearly very important information for the GP to have for the consultation. The fact that this information was not passed on indicates a need for the practice to check that guidance and processes are in place for the accurate taking and passing-on of important patient information.

(2) Dr [redacted] did not undertake any meaningful mental health or risk assessment during the consultation with Hazel.

(3) The GP practice undertook an internal review of Dr [redacted] consultation after Hazel's death (a Significant Event Analysis). This was attended by GP partners and the practice manager. The review did not identify that the GP practice admin did not pass on the concerns of suicidal thoughts to the GP. The review did not identify any insufficiency in Dr [redacted] mental health or risk assessment of Hazel. I am concerned that the GP practice may not be undertaking sufficiently robust internal reviews, and consequently is not recognising and addressing important issues in patient provision and safety and is not taking necessary corrective action.

	that the CCG will wish to consider these concerns given the CCG's relationship with GP practices within its area.
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 **19 August 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: - Dr [redacted] Linden Medical Group [redacted], son of Hazel Binks [redacted] daughter of Hazel Binks 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	**Dated: 23 June 2021**  **Peter Nieto, Area Coroner, for the Coroner Area of Derby & Derbyshire**