REGULATION 28: REPORT TO PREVENT FUTURE DEATHS.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • Dr [redacted], • Medical Director • Greater Manchester Mental Health NHS Trust (GMMH) • Trust HQ, • Prestwich Hospital, • Bury New Road, • Manchester • M25 3BL • Copied for interest to: • [redacted] – the deceased's mother
1	**CORONER** I am: Senior Coroner Nigel Meadows Senior Coroner for Manchester City Area HM Coroner's Court and Office Exchange Floor The Royal Exchange Building Cross Street Manchester M2 7EF
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 the 12/09/19 I commenced an investigation into the death of Antony Declan Schofield. The investigation concluded on the 23rd September 2021. The Conclusion of the inquest was**: Suicide**
4	**CIRCUMSTANCES OF THE DEATH** Mr. Schofield suffered from a recurrent depressive disorder and been taking antidepressant medication for many years. He had been trying to reduce his dosage but was experiencing discontinuation syndrome and had a mental health crisis on

the 6th August 2019. He was admitted to Safire Ward at Parkhouse psychiatric unit on the 8th of August after presenting at A&E two days before expressing suicidal thoughts. Unfortunately, he also had a significant family history of suicide. During the course of the admission he expressed suicidal ideation on several occasions but disclosed no current plan or intent. He did report ways in which he could kill himself but appeared willing to accept medication engage with services. He had tried hanging himself in the past but was discharged on the 20th August into the care of the community Home Based Treatment Team (HBTT). Before he was discharged a comprehensive suicide/self-harm risk assessment was not completed by a member of inpatient staff who had full knowledge of his condition and future care plan.

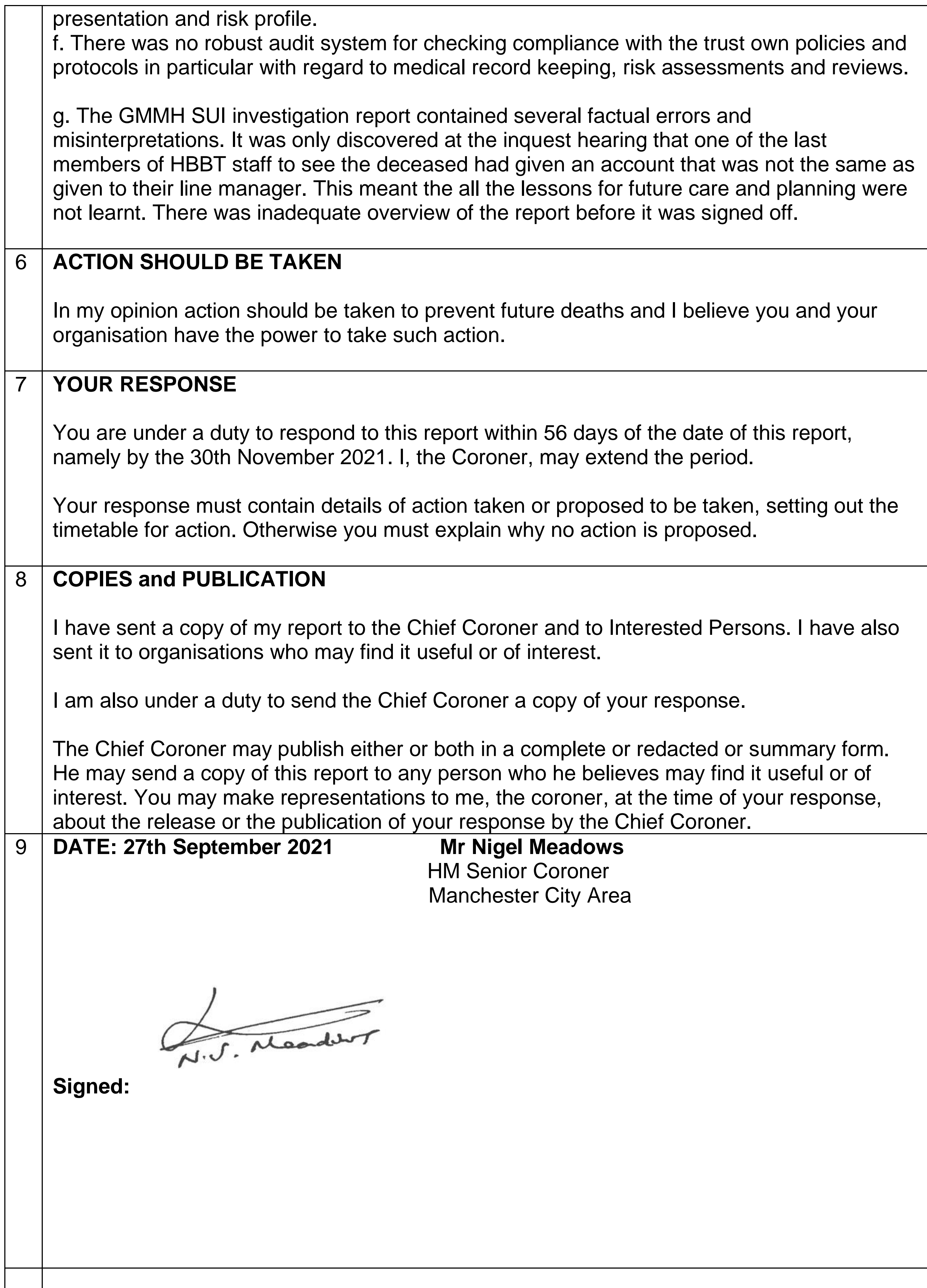
On the 22nd August he attended A&E and reported that he had attempted to end his life the night before and had bought [redacted] with the intention of ingesting it and killing himself. He subsequently had several contacts with the HBTT, the last of which was on the 26th August but previously when asked about it told them that he had received the drugs but thrown them away. He was found dead on the 27th of August at his home address having taken an overdose of [redacted].

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.
a. No thorough comprehensive risk review was undertaken by a member of staff who had detailed knowledge of the deceased prior to his discharge from the inpatient unit. This was not identified before he left the ward and it was not discovered by the HBTT when they took over his care.
b. The transfer and communication process from inpatient care to the HBTT appeared inadequate.
b. There was no clear plan to deal with the risk of his condition deteriorating and him experiencing significantly more suicidal thoughts as well as obtaining the means by which to kill himself. It is well known that a history of suicidal thoughts and actions increases the risk when they are repeated.
c. When he disclosed that he bought [redacted] there was no risk review planning involving a senior HBTT clinician which was then monitored even when he indicated that he had received it.
d. On several occasions before he died the deceased saw members of the HBTT but they failed to demonstrate professional curiosity and enquire about his suicidal thoughts and plans. There were either adequate or no records about this.
e. There were a number of missed opportunities for the HBTT to assess changes in his



presentation and risk profile.
f. There was no robust audit system for checking compliance with the trust own policies and protocols in particular with regard to medical record keeping, risk assessments and reviews.

g. The GMMH SUI investigation report contained several factual errors and misinterpretations. It was only discovered at the inquest hearing that one of the last members of HBBT staff to see the deceased had given an account that was not the same as given to their line manager. This meant the all the lessons for future care and planning were not learnt. There was inadequate overview of the report before it was signed off.

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 the 30th November 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 Interested Persons. I have also sent it to organisations 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 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 **DATE: 27th September 2021** **Mr Nigel Meadows**
HM Senior Coroner
Manchester City Area

N.J. Meadows

Signed: