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 • Dr. [redacted] – The Droylsden Road Family GP Practice 125 Droylsden Road, Manchester M40 1NT Copied for interest to: • [redacted] – the deceased's ex-partner • [redacted] – the deceased's daughter • [redacted] - the deceased's brother • The CQC
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 09/09/20 I commenced an investigation into the death of Darren John Lawrence. The investigation concluded on the 4th October 2021. The Conclusion of the inquest was**: Suicide**
4	**CIRCUMSTANCES OF THE DEATH**

Mr. Lawrence had a history of illicit drug use and first presented to mental health services in June 2018 after having [redacted] and was expressing delusional beliefs. He was detained under S.136 of the MHA. During his mental health assessment in hospital he then denied thoughts of suicide or self-harm. In May of 2019 he attended A&E after taking a [redacted] with the intention of ending his own life. He was detained for a short period of time under S.5(2) of the MHA. It was initially considered safe for him to be discharged home, but after further presentations he was detained under S.2 of the MHA later that month. During the course of this admission he exhibited some symptoms of psychosis but subsequently became an informal patient and was taking leave from the ward to visit his home and see family members.

He was discharged from hospital in June 2019 with initial support from the Home Based Treatment Team (HBTT) which resulted in him being under their care from the 26th June to the 5th July 2019 but had been referred to the Community Mental Health Team (CMHT) for longer term support. The HBTT is a service designed to give more intensive support for patients being treated in the community and is often an alternative to inpatient care. On the 16th August 2019 a joint HBTT and CMHT visit to see him took place. He seemed to be compliant with his medication and attended several out-patient appointments, but he was suffering from increased anxiety. His prescription of Mirtazapine was increased on the 3rd October 2019. The HBTT is a service designed to provide intensive support to patients in the community and is often an alternative to inpatient care.

He then failed to attend further appointments in November and December 2019 and one on the 9th January 2020 after which his "partner" notified the CMHT of a deterioration in his mood. On the 7th February 2020 an unannounced visit was made to his home and he voiced suicidal thoughts and plans and appeared depressed but was unwilling to become a voluntary patient in hospital. Concerns about his general welfare were identified and a referral made to HBTT.

On the 11th February 2020 he disclosed that he was still experiencing suicidal thoughts and struggled to find ways of distracting himself from them. The same day a CMHT ST5 doctor wrote a detailed 5 page letter to his GP Practice informing them of the treatment plan including "start Venlafaxine 37.5 mg BD. The GP to continue prescribing Mirtazapine." This letter was received by the GP Practice on an unknown date but was scanned into the GP Electronic records on the 9th April 2020. However, the GP did not see it or have it brought to their attention.

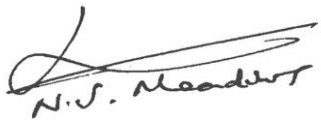
On the 17th February a CT2 HBTT doctor wrote to his GP Practice with a very short 3 line letter asking that them to take over the responsibility for prescribing the Venlafaxine. This letter was added to the GP records system on the 19th February 2020 and seen by the GP the following day. He requested his staff to arrange a phone appointment with the deceased because he wanted to review his mental health and discuss the letter with the deceased before the prescription was issued. In addition to check what other medication he was taking and answer any queries. The GP was still unaware of the existence or content of the letter of the 11th February.

On the 26th February the deceased refused entry to his home when a joint visit was made by members of both the CMHT and HBTT. The plan was then to transfer his care from the CMHT to the HBTT.

On the 2nd March 2020 the HBTT Consultant Psychiatrist wrote to the GP Practice summarising the recent medical history indicating that the Venlafaxine dose is increased to "225 mg mane, prescribed by HBT. Darren was discharged from HBTT back to the care of CMHT.GP to take over prescribing from 10/3/20." Whilst the GP received the

	correspondence, it was not added to the computer record system until the 30th March 2020 and on the same day a Locum GP requested that it was sent to the Pharmacist. The GP did not prescribe venlafaxine as was requested and was still unaware of the existence and content of the letter of the 11th February 2020. O The GP attempted to contact the deceased by phone on the 10th April 2020, but this was unsuccessful. A Text message was sent to the deceased requesting that he contact the GP but there was no response. On the 30th April 2020 an unknown member of staff recorded that no action was required. Consequently, the deceased was never prescribed Venlafaxine and did not receive the therapeutic benefit that the medication could provide. CMHT did not check whether this medication was actually being prescribed and collected by the deceased. On the 5th May 2020 his "partner" reported that there appeared to be no changes in his presentation despite the medication. No one in the HBTT or CMHT were aware that his relation ship with his "partner" had broken down 18 months before. Consequently, she was his "ex-partner". No direct contact was successfully made with the deceased thereafter. On the 3rd June 2020 a person described as his sister-in-law raised concerns with the contact centre regarding his welfare and escribes how he is not taking his medication and is currently unwell. This was referred to CMHT and a worker was assigned on the 11th June 2020 contact him by phone, but this was not attempted until the 25th June 2020. On the 24th July 2020 the GP Practice Pharmacist questioned the deceased's compliance with medication. No action was taken as a consequence and neither the GP Practice, HBTT or CMHT communicated with one another to recognise the true position. The deceased's ex-partner was asked to monitor him and report any concerns, but she was noted to have moved out of the home on the 19th August to stay with relatives and also that he was not doing well and there were long term housing and relationship problems. Their lifestyle was chaotic. No further contact was made with him and on the 29th August, he was found dead at his home address after [redacted]. It is well recognised in psychiatric practice that a patient with the history of disengagement with services and who does not take his medication that will probably lead to a deterioration in their mental health and increase the risk of self-harm or suicide.
5	**<u>CORONER'S CONCERNS</u>** 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.The transfer and communication process from the HBTT to the CMHT in 2019 and 2020 was unsatisfactory with inadequate follow up as required. The court has received evidence about similar problems in other inquests in which GMMH was the treating NHS Trust and is a repeated issue of concern. b. There was lack of appropriate escalation following the deceased's disengagement with community services in 2019 but also in 2020 when there was a repeated lack of direct contact with him as well as the recognition of its importance. From June 2020 no other methods were tried to have direct contact with the deceased apart from attempts from phone calls which were repeatedly unsuccessful. c. There was no consideration of referral back to the HBTT by the CMHT when the deceased may have benefited from it when circumstances changed. There was disengagement from services after the end of February 2020 as well as evidence of noncompliance with medication. d. There was no GMMH procedure or process to check regularly if the deceased was being prescribed the correct medication and it being collected. In addition his response to it. e. The GP practice failed to ensure that medication (for a patient with a serious mental health problem with a history of suicidal ideas, plans and previous attempts) was prescribed. This is despite them receiving letters from GMMH clinicians requesting this. Consequently, the deceased did not receive the therapeutic benefit the medication would have provided. f. The GP system for recording receipt of correspondence and ensuring that they were seen and reviewed by a GP was inadequate. As was communication with and from the Pharmacy team. Nor was there consideration of a system or process for contacting the secondary care provider GMMH in such circumstances when medication was not prescribed as requested and no contact could be made with the deceased. There was no escalation process/procedure. g. There was no CMHT/HBTT planned involvement with the GP in the overall management and treatment of the deceased apart from simply requesting that they issue repeat prescriptions. This meant that opportunities to develop other lines of communication and information sharing as well as support were lost. h. The CMHT Responsible Clinician was an important witness but the GMMH SUI investigation did not obtain a statement from him and the those carrying out the investigation failed to recognise the significance of this. Nor was this identified in the overview of the report before it was signed off. This meant the all the lessons for future care and planning were not learnt. The court has received evidence about the same issue in other inquests involving deaths of GMMH patients and is a repeated matter of concern
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 10th January 2022. 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: 15th October 2021** **Mr Nigel Meadows** HM Senior Coroner Manchester City Area  **Signed:**