## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO: The Secretary of State for The Department of Health and Social Care.** |
| 1 | **CORONER**<br><br>I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 18th February 2021 I commenced an investigation into the death of Laura Jane Medcalf. The investigation concluded on the 8th April 2022 and the conclusion was one of **Narrative:** Died from suicide contributed to by a failure by mental health services to recognise her deteriorating mental health and the increased risk she presented and to take effective steps to reduce the risk.<br>The medical cause of death was 1a Multi organ Failure; 1b Hypoxic Brain Injury;1c Asphyxiation on background of gabapentin toxicity |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Laura Jane Medcalf managed her mental health through exercise and controlling her food intake. The onset of Covid-19 restrictions and surgical interventions for her hydrocephalus meant that the routine she had relied on to manage her mental health was not available to her.<br>On 3rd December 2020 after considering taking her own life for a number of weeks Laura Jane Medcalf took an overdose of paracetamol. She was taken to Salford Royal Hospital after she told her family what she had done. On 4th December 2020 she was assessed as requiring a mental health bed. She consented to a mental health in-patient stay but would have been sectioned had she not consented. Shortage of mental health beds meant she was kept at Salford Royal Hospital until moving to a bed on the Medlock Ward on 10th December 2020.<br>She was discharged on 16th December 2020.<br>On 17th December 2020 she was assessed by the home-based treatment team who identified she needed to be re-admitted to the Medlock Ward. Whilst waiting for a bed she went to went to hospital due to concerns about keeping herself safe. She was readmitted to the Medlock Ward as a voluntary patient. She continued to be prescribed medication including gabapentin. She had disclosed that the discomfort from that neurosurgery had impacted her mental health. There was a failure to follow up a referral to the neuro team, this did not contribute to her death.<br>On 16th January 2021 she told staff on the ward she had taken a paracetamol |

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| | overdose and drunk vodka whilst on the ward. She was taken to hospital for treatment.<br>On 22nd January 2021 she returned to the Medlock ward. On 31st January 2021 she was found in her bed with a [redacted] There was a failure to complete a Datix incident form in compliance with trust policy.<br>On the afternoon of 9th February 2021, she was found in bed in her room with a [redacted]. She remained on level 3 observations and her room was searched. A risk assessment completed on 9th February recorded this incident but failed to analyse or explore how this impacted her risk. On the evening of 9th February about 8pm there was a further incident when she was found on checks by staff in her bed with a [redacted]. Her room was not searched. She was moved to level 2 observations but there was a failure to follow the trust policy in how these observations were implemented or subsequently stopped. On a check approximately 10 minutes later on 9th February 2021 she was again found with a [redacted]. Her rom was searched again. There was a failure to record these in a risk assessment or to adequately assess how the three incidents reflected a deterioration in her mental health and impacted on the risk she presented or how to mitigate further the risk of carrier bags.<br>On 14th and 15th February 2021, she was declining food according to the food charts. This was not recognised as a potential symptom that could reflect a deterioration in her mental health. On 14th February 2021 she told staff that she had had a day of bad thoughts. There was a failure to explore this or to assess If this presented an increased risk.<br>On 15th February 2021 she told staff she had had a bad day. There was a failure to link this to the disclosure of 14th February, to then explore this disclosure with her or to re-assess the risk she presented.<br>On 17th February 2021 on a level 3 check at about 12:10 am Laura Jane Medcalf was found in her bed in her room with a [redacted] Attempts were made to resuscitate her and she was transferred to Manchester Royal Infirmary. She died there on 17th February 2021.<br>A post-mortem examination included toxicology. It was found that she had an above therapeutic level of gabapentin in her system. Staff on the ward had failed to identify that she had possession of gabapentin in her room. She had died from a hypoxic brain injury caused by asphyxiation on a background of gabapentin toxicity.<br>A search of her room by GMP also found a [redacted] in her bedside table and a [redacted] in her dressing gown that staff had not realised she had possession of. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br>1. The inquest heard that Laura Medcalf was kept in an acute hospital setting at Salford Royal Hospital awaiting a mental health bed due to a shortage of mental |

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| | health beds. The inquest heard that there is a national shortage of inpatient beds and that this delay is not unusual.<br><br>2. The inquest heard that during the period of time that Laura Medcalf was an in-patient on a mental health ward there were significant staffing challenges. Those challenges were part of a national picture of availability of mental health staff. Against this background and in order to keep the ward staffed and fully operational the trust had to move staff from other mental health services; use agency/bank staff and use leadership and management staff to backfill for nursing staff.<br><br>3. The evidence before the inquest was that Covid 19 and the measures to deal with it had had a significant impact in a number of respects. In particular that included the impact of lockdown on the mental health of Laura Jane Medcalf. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 23/06/2022. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely, [redacted] (NOK), Greater Manchester Mental Health, Trafford Metropolitan Borough Council and The Care Quality Commission who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 |  <br>Alison Mutch<br>HM Senior Corner<br>HM Coroner's Court Manchester South |