REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **Secretary of State of Health & Social Care and Greater Manchester Health & Social care Partnership.**
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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 25th February 2021 I commenced an investigation into the death of Fadhia SEGULEH .The investigation concluded on the 10th August 2021 and the conclusion was one of narrative: Died from the complications of suspension from a ligature. The medical cause of death was 1a Diffuse Cerebral Oedema and Hypoxic Brain Injury 1b Asphyxia and Cardiac Arrest 1c Self hanging by ligature suspension
4	CIRCUMSTANCES OF THE DEATH Fadhia Seguleh was receiving treatment for anxiety and depression. On 24th February 2021 she was found unresponsive attached to a ligature at her home address [redacted] West Downs Road. Conclusion of the Coroner as to the death: Died from the complications of suspension from a ligature.
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. The inquest heard evidence that she was being treated by the NHS Mental Health Trust, GP and through private therapy provided by her employer. As a consequence, the professionals treating her did not have a full picture of disclosures made by her and professionals operated in silos. There was no protocol in place for information sharing between those involved and no policy to guide appropriate steps to obtain information. A query raised with the GP would have enabled a clearer picture of the issues to be held by the private provider. Information sharing would have provided a more rounded understanding of risks. The operation in silos meant that the treatment plan put in place by the mental health team including medication was not fully understood by the GP and was altered following a consultation between the GP and Fadhia. Information sharing between agencies would have allowed for a more detailed assessment of risk in the situation. 2. As a consequence of Covid all of the assessments of her by her GP in relation to her mental health were done via telephone. Prior to Covid it was likely that they would have been done face to face. It was accepted that assessments of mental health risk and understanding of need was far easier to assess face to face. 3. The inquest heard evidence that she had on a previous occasion been taken to A and E due to concerns that she would take her own life/self-harm. Due to Covid she had to go alone to A and E and was assessed alone without input from her family who were aware of the full picture. The experience of attending alone whilst experiencing mental health issues was deeply stressful for her and meant that she had been unsupported by her family at a time of crisis. In addition, the quality of information available was limited as a result of her being there alone.
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 22nd October 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 namely [redacted] (family of the deceased) and Pennine Care , 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	**27th August 2021**  **Alison Mutch** **HM Senior Coroner Greater Manchester South**