REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Wigan Discharge Team, Royal Albert Edward Infirmary, Wigan**
1	**CORONER** I am Rachel Raheela Syed, HM Assistant Coroner, for the coroner area of Manchester West
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 Wednesday 5th January 2022 I commenced an investigation into the death of Victoria Cartwright, 36. The investigation concluded at the end of the inquest on Thursday 16th June 2022. The medical cause of death was: 1a) Hypothermia 2) Alcohol Intoxication The conclusion of the inquest was 'Accident'.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was pronounced dead on the 26th December 2021, in the car park, rear of the Ball and Boot Pub, Orchard Street, Wigan. The deceased had a complicated medical history including a long battle with alcohol abuse, resulting in many hospital admissions, as a consequence of being found in the street intoxicated and unable to take care of herself. The deceased had completed a private detoxification and rehabilitation programme but despite this was unable to abstain from alcohol misuse. She was known her to local alcohol and mental health teams. On the 10th November 2021, she was admitted to hospital by the Police following welfare concerns. On the 19th November 2021, a Mental Health Team referral was made and an assessment revealed an impression that the deceased was suffering from alcohol related brain disease and Korsakoff's Syndrome. A Mental Health Clinician recommended a 24 hour care placement be put in place as the deceased would be unable to manage independently.

	Despite this recommendation, the deceased was discharged from hospital to a hotel used to house homeless individuals and the Mental Health Clinician was not notified of this decision. The deceased was readmitted back to hospital on the 21st December 2021, due to alcohol intoxication and the Mental Health Clinician reiterated that the deceased would require a 24 hour care placement and a Safeguarding and Social Care referral was made. From the evidence available, it is not possible to state the exact circumstances of when the deceased was next discharged from hospital. Closed circuit television footage reveals that on the 25th December 2021 at 20:35 hours, the deceased got out of a car and sat on a bench, before staggering to the location in the car park, rear of the Ball and Boot Pub where she was discovered dead the next day on the 26th December 2021, wearing unsuitable clothing for the weather conditions. Toxicology analysis reveals she had consumed large amounts of alcohol in the period leading to death. The Post Mortem findings conclude she had died from Hypothermia, which she developed whilst being under the influence of alcohol. There was no third-party involvement.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. Whilst is it accepted that no evidence was heard directly from the hospital about the specific circumstances of both hospital discharges, two witnesses attended the Inquest and during their evidence concerns were raised regarding lack of collaborative working with key external agencies during the discharge processes. The **MATTERS OF CONCERN** are as follows. – [redacted] Consultant Psychiatrist for Greater Manchester Mental Health Trust stated he had recommended a 24 hour care placement for Victoria to meet her clinical needs. Despite this, she was discharged from hospital to the Mercure Hotel, used to house homeless individuals. [redacted] stated that this hotel would have been unsuitable for Victoria's medical needs and following her readmission back to hospital, raised similar concerns. He also stated that he was never notified of Victoria's actual discharges. [redacted] a Recovery Co-Ordinator, employed by We Are With You (formerly Achieve) stated he was never invited to Victoria's MDT meeting and it would have been beneficial for his organisation to have been taken part in this meeting. He concurred that the Mercure Hotel would have been unsuitable accommodation to suit Victoria's complex needs and was not involved in the hospital discharge processes. Evidence highlights a lack of collaborative working between the discharge team, Wigan Hospital, GMMH and Achieve.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **Friday 12th August 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 the following Interested Persons. [redacted] mother of Victoria Cartwright I have also sent it to Greater Manchester Mental Health and We Are With You who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.	
9	**Date** **17th June 2022**	**Signed** Rachel Raheela Syed **Rachel Raheela Syed** **HM Assistant Coroner** **Manchester West**