REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Pennine Care NHS Foundation Trust**
1	**CORONER** I am Catherine McKenna, Area Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 12 May 2020 an investigation into the death of Sarah McGarrigle was commenced. The investigation concluded at the end of the inquest on 25 October 2021. I recorded the following Narrative Conclusion: The Deceased died as a consequence of the physical effects of alcohol dependency and self-neglect which had developed in the context of a long-standing mental disorder that had not been fully assessed and remained untreated at the time of her death.
4	**CIRCUMSTANCES OF DEATH** Sarah McGarrigle was 23 years old when she was found deceased at her home address on 1 March 2020. Post-mortem examination established that she died as a result of a catastrophic internal haemorrhage caused by a spontaneous rupture of oesophageal varices which had developed due to chronic alcohol use. The Deceased's dependence on alcohol had developed against a background of trauma and mental disorder. She had been known to mental health services since childhood and had been given various diagnoses which included anorexia, Asperger's, pathological demand avoidance and emerging borderline personality disorder. She had moved to the Oldham area in 2017 and came to the attention of Social Care because of safeguarding concerns raised by North West Ambulance Service (NWAS) in relation to her vulnerability, frequent calls and self-neglect. Between August and November 2019, the Deceased received continuous inpatient care for alcoholic hepatitis which was complicated by the development of multi-organ failure and a large variceal bleed which required management on the intensive care unit. Upon discharge, the Deceased initially expressed a wish to live with her family in Liverpool however by December, had returned to Oldham and her previous behaviours of self-neglect. On 10 January 2020, the allocated social worker for the Deceased requested a Mental Health Act assessment and specifically asked that consideration be given to whether she had a mental disorder which impaired her ability to make decisions in relation to treatment for her mental and physical health. Events were overtaken when the Deceased was brought to the Royal Oldham Hospital by NWAS on 13 January 2020 having vomited blood. The Deceased was detained under section 2 of the Mental Health Act 1983 after she had attempted to leave the department. The Approved Mental Health Practitioner (AMHP) who assessed the Deceased shared the concerns held by the allocated social worker that whilst the Deceased presented as an individual with capacity to make decisions, her ability to weigh the risks of not accepting treatment appeared to be impaired and queried whether this was linked to an underlying mental health disorder. She recommended that a thorough assessment of mental disorder and capacity take place. After receiving treatment for her physical condition, the Deceased was transferred to Aspen Ward on the evening of 22 January 2020. The mental health team responsible for assessing the Deceased were provided with information about the Deceased's history of involvement with mental health services, previous

	diagnoses, self-neglect, repeat and frequent calls to the ambulance service, disengagement with community services, moves between Liverpool and Oldham and the concerns of her family and social care regarding her likely compliance in the community. The significance of this information was not fully appreciated by those assessing the Deceased on Aspen Ward who took at face value the Deceased's assurance that she would be returning to Liverpool on discharge and that she would refrain from alcohol and engage with alcohol services. The Deceased was discharged on 28 January 2020 with a diagnosis of Mental and Behavioural Disorder due to Alcohol Dependency. The capacity assessment recommended by the social worker and AMHP did not take place. The Deceased initially returned to her family in Liverpool but this arrangement broke down within three weeks and she returned to Oldham and her previous patterns of behaviour. She was found deceased at her home address on 1 March 2020. The admission to Aspen Ward presented a significant opportunity to undertake a thorough assessment of the Deceased's mental disorder and consider whether it impaired her capacity to make decisions in relation to her mental and physical health treatment. This opportunity was missed by those responsible for the Deceased's care on Aspen Ward. Whilst the evidence did not meet the required standard to show that her death would have been averted had the assessment been undertaken, it would have informed whether and if so, which legal frameworks could be utilised by health and social care professionals seeking to safeguard the Deceased in the community.
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) That the clinicians on Aspen Ward did not consider relevant information provided to the ward by the allocated social worker and the AMHP in the assessment of the Deceased's mental disorder. There was an over-reliance on Sarah's presentation on the ward and insufficient consideration given to the concerns that had been raised by community agencies, her psychiatric history and behaviours in the community setting. (2) That the Consultant Psychiatrists who reviewed the Deceased on Aspen Ward made the assumption that concern about the Deceased's capacity were raised in the context of her withdrawal from alcohol. Consideration of the information that had been communicated to Aspen Ward (which included the specific limb of the capacity test that was in doubt) and a more longitudinal approach to the assessment would have shown that the concern related to the far more complex picture that the Deceased presented in the community and management of risks associated with self-neglect. This was not addressed by those responsible for assessing the Deceased on Aspen Ward.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 **14 January 2022** I, the Area 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:- • The family of the Deceased • Director of Adult Social Care for Oldham Council • Clinical Director of Emergency Care in Oldham, Northern Care Alliance I have also sent a copy to the following organisations who may find it of interest:- • Oldham Safeguarding Adults Board • The Care Quality Commission

	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 from. 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.
	Date: 19 November 2021 Signed: