REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Chief Executive, Pennine Care NHS Foundation Trust via their solicitors, [redacted]
1	CORONER I am Christopher Stephen Murray, Assistant 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 the 5th August 2020, The Coroner opened an Inquest into the death of Susan Mary Regan. The investigation concluded at the end of an inquest on the 27th April 2022. The conclusion of the inquest was a narrative form of conclusion of **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.** The cause of death was **1a) Hanging**
4	CIRCUMSTANCES OF THE DEATH Susan Regan was a 61 year old lady who had no relevant past mental health medical history. She was a long serving, well thought of, member of staff at Marks and Spencer. Her husband [redacted] died in 2017 and this did understandably affect her but save for some minor characteristic anxiety she had no recorded mental health issues. Following furlough from her role at Marks and Spencer, she began to deteriorate in terms of her mental health and her general wellbeing. She became malnourished and dehydrated combined with increasingly disturbed behaviour consistent with anxiety, arguably displaying potential psychotic tendencies and evidence of self-harm. This resulted in a consultation with the G.P. on 12th June 2020, involvement of The Mental Health Access Team on 5th June 2020, the appointment of The Home Based Treatment Team followed by admission to Stepping Hill Hospital in respect of the poor state of her mental and physical health, on 11th June 2020, followed

	by an assessment under the Mental Health Act on 14th June 2020 resulting in admission to a Mental Health Ward under section 2 of The Mental Health Act. Following improvement in her condition, the section was rescinded on 23rd June 2020 and Mrs Regan was discharged home with continuing support from The Home Based Treatment Team. There were ongoing symptoms and matters reached a head on 23rd July 2020 when Mrs Regan was reported to be at the end of her drive, screaming. Advice was sought and a visit planned for 24th July 2020 at which Mrs Regan was described as anxious, very agitated and rubbing her hands and face. Throughout a series of assessments over the months Mrs Regan would either deny suicidal ideation or avoiding answering the questions. She was known to not want to be hospitalised but her sons remained concerned that she be kept safe. Crucially, they were not consulted on this point 24th July 2020 contrary to the specific instructions of a Doctor when she was consulted on 24th July 2020. There was a failure to have a discussion with Mrs Regan's sons about their opinions on hospitalisation and the risks of not doing so. There was a further failure to record any reference to hospitalisation in their notes following the visit on the morning of 24th July 2020. Mrs Regan's dosage of diazepam was doubled and there appeared to be some improvement in her level of anxiety. A planned visit took place on the morning of 25th July 2020. Later that afternoon Mrs Regan took her own life by [redacted] as a ligature, around the neck, in [redacted] her home address.
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) During the course of the Inquest evidence emerged that the clinical guidance of a Doctor required the Home Treatment Team to speak to Ms Regan's sons to explore whether they feel she needed to be admitted on an inpatient psychiatric unit. Admission to also be considered if Ms Regan would continue to show non-compliance on her medications. Such an enquiry was not undertaken. 2) It was also confirmed in evidence that there was a failure to properly record a plan and properly communicate such a plan with Mrs Regan's sons.

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. 1. I am concerned that advice from senior clinicians was not followed and appropriate plans not drawn up by the Home Treatment Team.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 12th October 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 namely [redacted], on behalf of the Family, 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	**Christopher Stephen Murray** **HM Assistant Coroner**  **17.08.22**