REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Secretary of State for Health & Social Care Secretary of State at Ministry of Justice
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 6th October 2020 I commenced an investigation into the death of Michelle Louise Jennings. The investigation concluded on the 24th November 2021 and the conclusion was one of suicide. The medical cause of death was 1a hanging
4	CIRCUMSTANCES OF THE DEATH Michelle Louise Jennings had a history of contact with mental health services and had a history of indicating suicidal ideation to a number of agencies. She was assessed as being suitable for step 4 therapy. However at the time of the assessment of her need there was a 2 year waiting list to access therapy. On the balance of probabilities this delay possibly contributed to her death. On 11th April 2019, 17th July 2019, 28th July 2019, 17th January 2020 and 8th May 2020 she was dealt with by British Transport Police (BTP) and indicated suicidal thoughts. Following the incident on 8th May 2020 BTP prosecuted her for obstructing the railways when she had indicated she had suicidal ideation at the time she was on the railway. She was subsequently arrested on a warrant and held in custody before being sentenced. On the balance of probabilities this decision to prosecute possibly contributed to the deterioration in her mental health and her subsequent death. On 1st August 2020 following calls to the mental health crisis line she was referred for a mental health assessment by the Primary Care Mental Health Team (PCMHT) part of Cheshire & Wirral partnership NHS Trust (CWP). On 3rd September 2020 she was assessed by telephone by the PCMHT and then the case was referred to the PCMHT MDT. On 6th September she rang Cheshire Police from Delamere Forrest with suicidal

	thoughts. She was taken to Hospital and discharged the following day. On 9th September 2020 her case was considered by the PCMHT MDT. They determined her needs were too complex for the PCMHT and she was to be referred to the Community Mental Health Team (CMHT) part of CWP. The referral was not made until 16th September 2020. At the point of referral she was discharged from the PCMHT caseload. On 17th September 2020 she presented at Stepping Hill Hospital with suicidal thoughts. She was assessed by mental health services and discharged. On 23rd September 2020 she was discussed at the CMHT MDT where the referral was rejected and she was to be referred back to the PCMHT. She was discharged from the CMHT caseload at that point. She was no longer on the caseload of either the PCMHT or the CMHT. Despite the complexity of her needs and her deteriorating mental health there was no discussion between the PCMHT and the CMHT in relation as to how to manage or mitigate the risk at this point although it was documented that she felt rejected by mental health services. On the balance of probabilities the poor communication between the PCMHT and the CMHT, the failure to assess risk effectively to ensure she remained on the caseload of either the PCMHT or the CMHT probably contributed to the further decline in her mental health and her death. On 3rd October 2020 she made her way [redacted] and hanged herself [redacted] She was found on 5th October 2020.
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 the backlogs for therapy were such that the waiting list at the time she was assessed as being appropriate for step 4 therapy had a two year wait time. Since that time the waiting period had not decreased and was now between 2 -3 years in both primary and secondary care. This was due to a shortage of trained therapists and demands on the service and was a national issue not specific to the CWP trust. 2. The inquest was told that the trust had since Michelle's death recognised that the lack of ownership created through the application of its referral and discharge policy internally carried an unacceptable risk. Significant changes had been made. However it was unclear if nationally the lesson had been shared and that other mental health trusts had taken similar steps. 3. The evidence before the inquest was that there needed to be a clear understanding by all prosecuting authorities of the impact of a prosecution on someone with a complex mental health background such as Michelle. In Michelle's case the BTP file reviewer (the nature of the offence Michelle faced meant that it was not a CPS lawyer who made the charging decision) had not correctly applied the public interest test and had not considered the mental health/vulnerability of Michelle Jennings as required to. As a consequence a decision was taken to prosecute her without an assessment of the impact on Michelle and her case was dealt

	with by the Magistrates Court without them being given the full background in relation to her deteriorating mental health. BTP are as a consequence of Michelle's death taking steps to address how their prosecution teams should deal with the public interest test and gather information where mental health is an issue. However there is no clear mechanism for such learning and changes (to reduce the risk to life) in relation to vulnerable people such as Michelle to be implemented within the other 42 Police Forces in England and Wales or within other agencies responsible for prosecuting criminal offences.
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 6th April 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 the Family, Pennine Care, Cheshire & Wirral Partnership NHS, and Cheshire West & Chester Council 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	**Date 9th February 2022**  **Ms Alison Mutch** **HM Senior Coroner Manchester South**