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:** Minister for the Department of Health – Rt Hon Steve Barclay MP
1	**CORONER** Miss Lorraine Harris, Area Coroner, East Riding of Yorkshire and City of Kingston Upon Hull.
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 27th May 2022 I commenced an investigation into the death of Scott James DONOGHUE, aged 33 years. The investigation concluded at the end of the inquest on 28th September 2023. The conclusion of the inquest was Suicide. Box 3 of the record of inquest read: Scott James DONOGHUE had a history of anxiety but in 2022 developed depression. He came under the care of the Home Based Mental Health Team (HBTT) following visiting the Humber Bridge with a wish to end his life on 7th May 2022. Mr Donoghue agreed to engage with HBTT and was awaiting an arranged handover to the Community Team. During this period, Mr Donoghue raised his concern at the lack of continuity of staff that were assigned to oversee his care plan. He specifically told HBTT that he would sometimes put on a front with new faces to make him look okay when he was struggling. The lack of continuity more than minimally hindered his ability to engage and receive the best level of care. On 24th May 2022, [redacted] He was 33 years of age. His medical cause of death was recorded as: 1a Hanging

4	**CIRCUMSTANCES OF THE DEATH** Mr Donoghue was an intelligent and high achieving individual who was part of a loving relationship. He had a history of anxiety but developed depression following the loss of his mother through suicide in January 2022, some childhood issues and frustrations over the care of his young poorly daughter. He had made previous attempts to end his life including using a ligature 4 years previously, an overdose on 28/02/2022, overdose attempts in April 2022. On 7th May 2022 Mr Donoghue was taken by police to Miranda House (a place of support for mental health) after he attended the Humber Bridge with the intention to end his life. Mr Donoghue indicated to staff at Miranda House that he wanted help; he was assessed, did not want admission and opted for being treated by the Home Based Treatment Team (HBTT). During May 2022 Scott spoke about hanging himself to his partner, [redacted]. The HBTT conducted a series of visits while he awaited a date to be moved to the Community Mental Health Team where he would have had one person having oversight of his care. Due to the need for 24 hour a day/7 days a week HBTT service, the court heard that continuity of care by either one person or a small group of people was not possible. Mr Donoghue raised concerns on more than one occasion about the lack of continuity of the people overseeing his care, he specifically told them that he could sometimes put on a front with new faces to make him look okay when he was actually struggling. Mr Donoghue used a ligature and hanged himself at his home on 24th May 2022.
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 could 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) It was evident that the lack of consistency in staff dealing with Mr Donoghue's care was a factor in his ability to engage and be honest with those having oversight of him at a very fragile time in his treatment. (2) Evidence was heard that the HBTT system is a nationwide treatment as

	an alternative to hospital admission and although peoples' care in HBTT had improved, a real continuity of staff could only occur with a substantive change which would include additional funding, recruitment of appropriate staff and an ability to retain staff. I was informed that if these issues were addressed it would allow more capacity to manage consistency alongside the other demands of the service. (3) It is worthy of note that this is the 2nd inquest heard within 3 weeks in this jurisdiction whereby inconsistency of care staff has been cited as an issue in a suicide. The other inquest was the death of a 20 year old woman. (4) Mental Health is a rising problem and it is my understanding that 115 people die by suicide every week. Acknowledgement of the important work undertaken by HBTT and the need to give the very best support to those who have taken the, often difficult, step of seeking help with their care is a matter that requires imminent attention.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your department/organisation 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 Friday 24th November 2023. 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 • The family of Scott James DONOGHUE • The family of Hollie Louise TENNENT • The Humber Mental Health Trust • The ICB for Humber 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]** ***28th September 2023***	**[SIGNED BY CORONER]** ***Lorraine Harris***