# REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br>**THIS REPORT IS BEING SENT TO:**<br>1. [redacted], **Chief Executive, Pennine Care NHS Foundation Trust** |
| 1 | **CORONER**<br>I am Catherine McKenna, Area Coroner for the Coroner area of Manchester North |
| 2 | **CORONER'S LEGAL POWERS**<br>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**<br>On 20 June 2023, an investigation into the death of Teresa Chmielek was commenced. The investigation concluded at the end of the inquest on 23 November 2023, I recorded a conclusion of suicide. |
| 4 | **CIRCUMSTANCES OF DEATH**<br>On 17 June 2023, the Deceased took her own life at her home address [redacted]<br>12 days before her death, the Deceased had been referred to mental health services by an Advanced Nurse Practitioner at the GP practice who had concerns about her risk of suicide. The referral was dealt with by the Single Point of Entry (SPoE) for Older People at the Royal Oldham Hospital and the Deceased was discussed at a screening MDT meeting which took place on 8 June 2023.<br>Despite the fact that the referral included the fact that the Deceased was reported to have made a recent attempt to take her own life, the referral was rejected without any contact having been made with the Deceased or a face to face review. |
| 5 | **CORONER'S CONCERNS**<br>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.<br>The MATTERS OF CONCERN are as follows:-<br>(1) The notes made by the SPoE Nurse for use during discussion at the screening MDT meeting did not include any reference to the report of a recent suicide attempt and the Court was not satisfied that the risk of suicide had been identified or recognised by the SPoE Nurse<br>(2) The Court heard that the practice at the screening MDT meeting was for the SPoE Nurse to read out the contents of the referral to the Psychiatrist who would then advise on next steps. There was no evidence to show that any form of meaningful multi-team discussion took place at the screening MDT meeting<br>(3) There was no direct contact between the mental health team and the Deceased (either by telephone or in person) before the decision to reject the referral was made<br>(4) The Consultant Psychiatrist present at the MDT meeting has no recollection of discussing the referral and whilst the evidence was that a letter to the GP practice explaining the reason for rejecting the referral was generated there is no record of this letter on the Trust's electronic systems or having been received by the GP practice |

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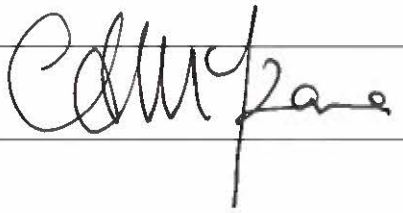
| | (5) The evidence was that there is no member of staff allocated to deal with referrals when the SPoE Nurse is absent from work which means that during their absence, urgent referrals are not being reviewed.<br><br>(6) There is currently no Standard Operating Procedure on how referrals into the SPoE Older Adults should be managed<br><br>(7) There is currently no system by which the management of referrals into the SPoE and related decision-making are audited. As such there is a risk that poor quality decision-making is going unchecked. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>**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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely 19 January 2024. I, the Area Coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely:- Family of the Deceased<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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: 24 November 2023 Signed:  |