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 and Social Care
1	CORONER I am, Alison Mutch, HM Senior Coroner, for the coroner area of South Manchester
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 15th February 2023 I commenced an investigation into the death of Shahzadi Khan. The investigation concluded on the 23rd November 2023 and the conclusion was one of **Narrative: Suicide contributed to by a failure to effectively and appropriately manage her care in the community following discharge from hospital.** The medical cause of death was **1a) Drug Toxicity.**
4	CIRCUMSTANCES OF THE DEATH On 29th December 2022, Shahzadi Khan was detained under section 2 of the Mental Health Act due to her mental state and the risks she presented. She was found to have had a manic episode with psychotic symptoms. Due to a lack of beds, she was placed in a privately-run mental health hospital in Norfolk. She remained there until her discharge to the family home on 26th January 2023. She was commenced on Olanzapine and Zopiclone for her mental health whilst an inpatient. Her diagnosis on discharge was mania with psychotic symptoms. She was to remain on olanzapine in the community. Her placement out of area contributed to disjointed and inadequate discharge planning to support her in the community and was exacerbated by poor communication between the team managing out of area placements and the local team. As a consequence, the aftercare planning did not take place in accordance with S117 Mental Health Act. This was exacerbated by a failure by all health professionals involved in her care within the mental health trust to recognise that she needed to be referred on to the Trafford Shared Care pathway. A referral would have ensured she received support and care for at least 12 weeks when she

	returned to the community. There is no clear reason for this failure. She was seen by the Home-Based Treatment Team (HBTT) on 28th January and 2nd February, then discharged back to her GP. Within a week of that discharge from HBTT, which meant she had been left with no mental health support, she had deteriorated significantly. On 9th February her GP sent her to hospital for emergency assessment due to her presentation. She was discharged home to be seen by the Home-Based Treatment Team on 11th February. She was seen by that team on 11th, 12th, and 13th February. There was still no recognition of the fact that the Trafford policy was not being followed. She had indicated her lack of compliance with olanzapine, suicidal thoughts and her behaviour on 13th February was erratic. On 14th February 203 she took a fatal overdose of prescribed zopiclone at 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. The inquest heard evidence that a shortage of mental health beds nationally meant that the situation that arose here of a placement out of area many miles from home was not unusual and that private beds were being used on a regular basis due to a shortage of NHS beds. The inquest heard that this meant that there were a number of consequences as a result all of such placements which could as in Ms Khan's case impact on a patient and increase the risk they presented. In particular: • A family could not easily stay in contact and visiting was almost impossible. This meant a patient felt more isolated and their family could not provide information effectively to the treating clinicians. • Where a non-NHS bed was being used or an out of trust bed was being used notes were not easily shared as different electronic systems were used. • Out of area trusts/private providers would not be familiar with local arrangements to support discharge and had to rely on local trust teams to put plans in place which could as in this case lead to less effective communication 2. There was evidence from her family that her deterioration was in part due to her going through the menopause and that had there been better awareness of this as a factor in mental health deterioration for some women and better support in place, interventions could have taken place at an earlier stage and been

	more effective. 3. The inquest heard that due to its size the mental health trust covers a number of areas. Each area has its own systems and pathways. Lack of understanding of these pathways by coordinating teams meant that patients were not being moved onto the correct pathway for care. The inquest heard that this was compounded by a lack of awareness by the Trafford HBTT of the local pathway for a patient such as Ms Khan and the need for a clear discharge plan to be in place that was understood by all those involved in a patient's care including her family and mental health care workers.
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 25th March 2024. 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 1) Mrs Khan on behalf of the Family; 2) Greater Manchester Mental Health NHS Foundation Trust and; 3) Southern Hill Hospital, 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	**Alison Mutch** **HM Senior Coroner**  **29.01.2024**