Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 NHS England**
1	**CORONER** I am Sarah MURPHY, Assistant Coroner for the coroner area of Cheshire
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 29 September 2023 I commenced an investigation into the death of Emma Louise MORRIS aged 39. The investigation concluded at the end of the inquest on 15 May 2024. The conclusion of the inquest was that: Suicide
4	**CIRCUMSTANCES OF THE DEATH** Emma Morris had a medical history of anxiety and depression. She had suffered a deterioration in her mental health and on the 20th September 2023, deliberately walked in front of a bus on the slip road of junction 39, Chester, heading towards the A55. A gatekeeping assessment had been completed by a mental health practitioner of the Crisis Resolution and Home Treatment Team on the 19th September where the practitioner found that an informal inpatient admission to a mental health ward was clinically indicated, but this could not be facilitated immediately as there were no beds available nationally. She was therefore under the care of the Crisis Resolution Home Treatment Team at the time of death.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) The gatekeeping assessment included a mental health state examination, where it was the clinical opinion of the mental health practitioner from the Crisis Resolution Home Treatment Team, that Ms Morris required an inpatient hospital admission to a mental health ward as there was an immediate risk to her safety as she was found to be a high risk of walking in front of a car. Whilst Ms Morris agreed to an informal admission, this was not possible at the time of assessment as there were no beds available nationally within the NHS or privately. As an inpatient admission was not possible, the option was to attend the Accident and

	Emergency Department or to remain in the community whilst waiting for an inpatient mental health bed to become available. Ms Morris had been informed that if she attended the Accident and Emergency Department, there could be a wait of three days for an inpatient mental health bed to become available. Ms Morris did not wish to wait in the Accident and Emergency Department for three days. A safety plan was agreed that Ms Morris would stay overnight with a family member, and would remain under the care of the Crisis Resolution Home Treatment Team who would review the following morning. The family felt that it was pushed for Ms Morris to stay overnight with a family member as there was no alternative to keep her safe. During the course of the inquest, I heard that there is national pressure on hospital trusts as there is a national increase in people waiting for inpatient beds. I am therefore concerned that there is a risk of future deaths as it is not possible to access inpatient mental health beds at the time of clinical need.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your 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 July 15, 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 **The family of Emma Morris** **Cheshire and Wirral Partnership NHS Foundation Trust** 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 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 by the Chief Coroner.
9	**Dated: 21/05/2024** Sarah Murphy. **Sarah MURPHY** **Assistant Coroner for**

	Cheshire