REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Somerset Foundation Trust at** Trust Management Office: Level 1, Yeovil District Hospital, Yeovil BA21 4AT 2. **National Institute for Healthcare and Clinical Excellence (NICE) at** 2nd Floor, 2 Redman Place, London E20 1JQ and [redacted] 3. **NHS England at** [redacted]
1	**CORONER** I am Samantha Marsh, Senior Coroner for the coronial area of Somerset
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 31st October 2023 I commenced an investigation into the death of Michelle Patricia Moore. Michelle was 42 years old. The investigation concluded at the end of the inquest on 25th June 2024. The conclusion of the inquest was a short-form conclusion of Suicide. The medical cause of death was: Ia) Compression of the neck Ib) Suspension by a ligature
4	**CIRCUMSTANCES OF THE DEATH** Mrs Moore had a lifelong history of anxiety and had difficulties in managing her emotions. She was unable to use distraction and de-escalation techniques taught to her by the mental health services as she was never able to 'ground herself' to fully utilise them and any de-escalation was short lived. In the 18 months prior to her death her mental health had noticeably declined. Mrs Moore herself could not identify any particular event, trigger or stressor for this when engaging with mental health professionals. Mrs Moore had first contacted her GP back in November 2019 (aged 37) as she was concerned about the menopause. There were no further recorded consultations or investigations in this regard until Mrs Moore had a consultation with the GP on the 27thJanuary 2023 when she expressed further

	concern about menopausal/perimenopausal symptoms. There were multiple secondary investigations concerning gastro and blood hormone tests, but these all came back as normal. The results of multiple clinical investigations did not reveal that there was anything sinister going on. Blood hormone tests were also not indicative of hormone changes to indicate menopause, but Mrs Moore was insistent as to the severity of her symptoms and so was started on HRT, which appeared to be clinically appropriate to trial to see if this alleviated her symptoms at all. Mrs Moore's underlying anxiety pre-disposed her to being very suggestive as to the potential side-effects of medication, as she would research them online and then develop these symptoms very quickly after commencement. Consequently, she was unable to tolerate the HRT (either orally or in patch form) for long enough to give the medication a sufficient trial to ascertain whether it helped alleviate her menopausal symptoms. She stopped taking HRT on the 17th April 2023 and did not re-start. Mrs Moore had multiple attendances and contacts with the GP, 111, Ambulance service, A&E departments and Secondary care between January 2023 and her death in October 2023; there were over 30 contacts, appointments and call-outs that related to physical symptoms. Between the 7th May 2023 and the 5th August 2023, Mrs Moore was under the care of the Home Treatment Team. She had a second episode of being under their care between the 26th September and her death on the 31st October 2023, and during these periods she had almost daily contact (sometimes multiple times a day) with the mental health teams. This was in addition to the contacts above. Mrs Moore had two acute voluntary admissions; one in a Step-Up setting (an alternative setting to an admission if there is no bed) and one to the Rydon Ward (an acute mental health ward). She was keen to avoid admissions in the future as she disliked the environment and those treating her appeared to agree that admissions had the potential to make Mrs Moore worse by increasing her anxiety and distress. Mrs Moore met with a consultant psychiatrist from the Community Mental Health Team on the 30th October 2023 and did not present in any way that gave immediate concern for her welfare and safety (over and above her baseline presentation). She was due to see a consultant psychiatrist from the Home Treatment Team the following day as part of a fluid discharge from one service to another. On the morning of the 31st October 2023, Mrs Moore was discovered deceased in her [redacted] home. [redacted]. Whilst Mrs Moore had a long history of mental health anxiety, her mental health had declined acutely and severely in the 18 months prior to her death and there was no immediately identifiable life event (i.e. of a social, relationship or economic nature) that could account for her acute deterioration over this period. She had never before tried to harm herself to any significant extent and/or attempt to take her own life.
5	**CORONER'S CONCERNS**

	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. – There appeared to be a lack of continuity and joined-up care between those trying to treat Mrs Moore's menopausal symptoms and those trying to treat her mental health presentation and this suggested: (a) A lack of understanding and appreciation of the menopause and the effect this hormonal change and/or imbalance may have on women; and (b) A lack of understanding and appreciation of a potential link between menopause and a woman experiencing mental health decline. I referred in questioning to the recognised mental health conditions of Post Natal Depression (PND) and Post Natal Psychosis (PNP) where it appears to be more widely understood and appreciated amongst treating professionals that childbirth and the hormonal imbalance/upheaval can acutely affect a woman's mental wellbeing and state of mind. However, the same awareness and/or appreciation does not appear to exist when, later in life, a woman may suffer a mental health decline due to acute hormonal changes brought about by the menopause (whether or not this is treated with HRT). There appears to be a complete absence of national and/or local guidance or published policy (none was brought to my attention on questioning of the clinicians) concerning: (a) The potential for a link between menopause and mental health decline. (b) The need for joined-up care between those trying to treat women at this stage of their lives. (c) Training and learning around hormone levels, HRT and antidepressants and the potential for a holistic approach to inform awareness and understanding.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 4th September 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: [redacted] I have also sent it to the following, who may find it useful or of interest: • The Menopause Charity 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	 **26th June 2024**