MS N J MUNDY
H M CORONER
SOUTH YORKSHIRE (East District)

email: [redacted]

CORONER'S COURT AND OFFICE
CROWN COURT
COLLEGE ROAD
DONCASTER DN1 3HS

Tel: [redacted]
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REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Chief Executive Officer and [redacted], Acting Medical Director, Rotherham Doncaster and South Humber NHS Foundation Trust

1. CORONER

I am Ms N J Mundy for South Yorkshire East

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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3. INVESTIGATION and INQUEST

On 9 April 2024 I commenced an investigation into the death of Carol Ann Guest. The investigation concluded at the end of the inquest . The conclusion of the inquest was

Suicide.

1a Hanging

1b

1c

II

4. CIRCUMSTANCES OF THE DEATH

Carol Ann Guest resided at home with her partner and did not have a history of mental health problems until 2024. These appear to have been triggered by her mother (for whom she had been caring for for a considerable period of time) being admitted to a care home. There were references in the GP notes to Ms Guest and her family seeking help and support in relation to mental health difficulties, which the family felt were escalating. On the 8th March 2024 a family member contacted the GP expressing concerns regarding escalation of symptoms and Ms Guest having taken excess medication the previous week. The GP did not feel a telephone call that day was indicated but did feel that urgent referral was necessary but regrettably the urgent referral was not sent until a week later. Once received by yourselves on Friday the 15th March, Mrs Guest's referral was placed on the SPA meeting list for the following Thursday (the 20th March) where it was discussed and determined that she would not follow the usual pathway and wait for a routine appointment but that a consultant would visit her the following week. Before that visit could be arranged Ms Guest hanged herself [redacted] at her home address on the 24th March 2024.

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 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. –

During the course of the evidence from both family and medical witnesses it became clear that there were no adequate systems in place for providing crisis support to patients over the age of 65. The family were very concerned and very frustrated by the futile attempts they made to secure psychiatric input and support when they could see a rapidly deteriorating picture. There was no explanation as to why individuals in crisis who were 65 or under had access to the crisis service but once a person is over 65 that service is no longer available to them. It is not clear whether access to such services would have altered the outcome but the current structure and services available in my view denied Ms Guest with the opportunity of obtaining specialist assessment support at a much earlier stage. A further concern was that the GP surgery provides patients with the crisis number seemingly without appreciating that this would only be available to those who were 65 or under. Furthermore, the family's evidence was that when they called 101 seeking medical input and support for Ms Guest, they were told they would be referred to the crisis team but as soon as Ms Guest's age was mentioned they halted that process and said that they would not be able to refer her after all because of her age.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you, [redacted] and [redacted] have the power to take such action and I invite you to give consideration to the following:.

1. Review of the crisis provisions as a whole,

2. Review of crisis services for those aged over 65 years,

3. Consideration of the accuracy of information disseminated to general practitioners so they are clear as to the nature and extent of any support services available to patients via your organisation..

4. If you consider any changes are necessary to bridge the gap with regard to crisis support availability for those over 65, consideration of any stakeholders, such as 101, you find should be notified of any change in services available.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by the **31st October 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to [redacted] .

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.

5 September 2024

Signature

Ms N J Mundy LL.B (hons)

Senior Coroner for South Yorkshire East