REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) GTD Healthcare 2) Secretary of State for Health and Social Care
1	CORONER I am Alison Mutch, 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 7th June 2024 I commenced an investigation into the death of Leslie Andrew SWINDELLS .The investigation concluded on the 4th October 2024 and the conclusion was one of narrative: **Died from the consequences of a self-inflicted puncture wound when his deteriorating mental health condition was not sufficiently recognised or acted upon within the primary care setting when he sought help. The medical cause of death was 1a) Exsanguination 1b) Transection of the right internal jugular vein 1c) Puncture wounds to the neck**
4	CIRCUMSTANCES OF THE DEATH Leslie Andrew Swindells had a complex mental health background. He was prescribed olanzapine and venlafaxine for his mental health and had been stable within the community. In May 2024 he started to display symptoms consistent with his mental health deteriorating including symptoms of paranoia. His family contacted the GP practice on 21st May 2024 with their concerns. An appointment was made for 2 days later with a mental health assistant practitioner. He should have been offered a same day appointment or referred to the Emergency Department. On 23rd May 2024 he spoke to a mental health assistant practitioner who was not qualified to assess him or his needs. They lacked the expertise to deal with him. A referral was to be made to secondary care. It was not made. His deteriorating condition and the increased risk he presented was not recognised due to the lack of experience of the practitioner and steps to mitigate the risk were not taken. He was not given any safety netting advice, was not escalated to a GP to be seen that day, his suicidal ideation was not explored. He was told he would be contacted following a referral. His mental health continued to deteriorate and on 29th May 2021

	he was found unresponsive at his home address [redacted] from self-inflicted puncture wounds to the neck.
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. – 1. The inquest heard evidence that the practitioner who saw Mr Swindells had very limited training in mental health and was employed in a role described as a mental health assistant practitioner. The evidence was that there was limited understanding of the scope of their role by GPs and what was covered by the term routine mental health appointments. 2. In Mr Swindells case the evidence was that he should never have had a review undertaken by someone with such a limited an understanding of mental health and that lack of understanding of mental health meant that the practitioner did not recognise the level of risk Mr Swindells posed. 3. The appointment had been booked via the reception team with no triage by a doctor following a telephone call to the practice. The evidence was that a shortage of trained reception/admin staff meant that an agency worker was screening calls that day and had a limited understanding of how patients needed to be allocated. 4. The evidence was that where GP practices chose to deploy staff with such limited qualifications to see those who needed treatment for their mental health it was essential that all those in the practice understood the limitations of the role and that there was close supervision of the practitioner. 5. The inquest heard that it was envisaged by the practice that the GP on duty would have a supervisory role. However it was unclear how this operated other than by the mental health assistant escalating a concern to the duty GP. 6. The assessment was carried out by telephone. The inquest was told that approximately 80% of the practitioner's mental health reviews took place in this way although it was accepted in evidence that it was far more challenging to assess an individual's mental health via telephone than face to face. During the conversation the practitioner did not identify their role or their qualifications to Mr Swindells. 7. The documentation of the practitioner was poor and did not reflect

	the content of the conversation which had been recorded and was available to the inquest. 8. Practitioners such as the one who saw Mr Swindells are not part of a professional /supervisory body.
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 12th December 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 [redacted], [redacted] on behalf of the family, 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**  **17/10/2024**