## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**The SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE** |
| 1 | **CORONER**<br><br>I am Adrian Farrow, Assistant Coroner, for the coroner area of Greater Manchester South |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 28th March 2024 an investigation was commenced into the death of Antony Williamson, aged 63. The investigation concluded at the end of the inquest on 17th December 2024. The conclusion of the inquest was that Mr Williamson **died from dry drowning** and took his own life whilst experiencing hopelessness in the investigation and treatment of pelvic pain. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mr Williamson began to suffer from lower urinary tract symptoms towards the end of 2022. Until that time, he had been fit and healthy and was working full time. Specialist urological investigations began in January 2023 and by March 2023 a diagnosis of chronic prostatitis was made. The condition adversely affected his life, his business and his mental health such that he was diagnosed by his GP with anxiety in April 2023.<br><br>Further urological investigations in May 2023 did not reveal any sinister cause of the symptoms and he was started on antidepressant medication by his GP. He had repeated consultations with his GP arising from the stress and pain associated with his condition and was diagnosed by the endocrinology team in July 2023 with syndrome of inappropriate antidiuretic hormone (SIADH), but subsequent tests did not identify a cause.<br><br>He began to experience suicidal thoughts in early July 2023 and continued to consult his GP through August 2023 with increasing suicidal thoughts arising from the physical symptoms and pain. He attended A&E on 21st August 2023, where the symptoms were attributed to chronic prostatitis and he was referred back to GP in relation to his mental health. At the instigation of his GP, Mr Williamson attended A&E for an urgent mental health assessment by the Mental Health Liaison Team in light of his increasing suicidal thoughts which resulted in follow up by the Home Based Treatment Team (HBTT) and a referral for talking therapy.<br><br>On 1st September 2023, as a result of a follow-up consultation with the urology team, Mr Williamson was referred to the Pain Service. The urology team had not further plans to see him again, having exhausted their investigations. |

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| | On 4th September 2023, Mr Williamson was reported to the police by his family to be missing from home. He had by that time ceased his business due to the medical and mental health issues and on that day, he took the car keys from home, which his wife had been keeping from him in order to keep him safe. . He presented himself to hospital some hours later and told the police that he had been unable to kill himself because he could not think of a way to do so without involving a third party. He expressed the view that his physical health problems were not being taken seriously and that he had previously tried to jump from a moving car. The mental health assessment resulted in an overnight admission to a mental health ward. On discharge, he came under the care of the HBTT and remained so until 19th December 2023.<br><br>The physical symptoms, pain and an increasing sense of futility were the theme of the following weeks with suicidal ideation resulting. Mr Williamson's wife obtained an urgent appointment with the Pain Service on 7th November 2023 for chronic pelvic pain. That consultation resulted in a referral to the specialist pelvic physiotherapist for assessment and a change of medication. The physiotherapy appointment did not take place before 19th December 2023. However, the following day, the HBTT adjusted the antidepressant medication again without liaison with the Pain Service.<br><br>On 13th November 2023, Mr Williamson told his GP that he had threatened to slash his wrists with a knife the previous evening and that the change in his medication was adversely affecting him.<br><br>On 19th November 2023, Mr Williamson was taken to A&E by his family because they feared he was about to jump from a window at home. He was assessed and admitted to a mental health ward for the second time as a voluntary patient remaining there until he discharged himself against advice on 24th November 2023 due to the conditions on the ward, which has since been closed. Immediately after his discharge, he absconded and was found by the police and his family at a local water park where he had intended to drown himself. He was seen by the HBTT two days later but was not made the subject of daily monitoring. He was assessed by the consultant psychiatrist from the HBTT on 30th November 2023 and by this time, Mr Williamson's family were keeping him locked in the house for his own safety.<br><br>Mr Williamson was catheterised at A&E due to urine retention on 8th December 2023. On 12th December 2023, Mr Williamson and his wife told the HBTT member visiting him that they perceived a disconnection between the medical and mental health teams in relation to his care and requested liaison between the HBTT and urology to achieve coordination. That request was raised within the HBTT and a further request made by the HBTT member on 17th December 2023 to the medical doctor attached to the HBTT but no such liaison took place.<br><br>The evidence at the inquest was that the HBTT largely relied upon Mr Williamson himself and his family for their understanding of the involvement, investigation and treatment by the medical teams. The medical specialties relied on the GP being a "hub" for communication by way of discharge and clinic letters, which were copied to Mr Williamson. The inquest found that the absence of a collaborative and coordinated approach between medical and mental health teams contributed to a feeling of hopelessness in Mr Williamson.<br><br>Mr Williamson left his home on foot having climbed through a window on 19th December 2023 and the finding of the inquest was that he entered an unidentified stretch of extremely cold water some time afterwards. The medical cause of his death was dry drowning due to a laryngeal spasm caused by the effect of immersion in cold water. His body was found on 17th March 2024 in the River Mersey some miles from his home. |
| 5 | **CORONER'S CONCERNS**<br><br>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 |

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| | circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>Throughout the inquest, it was apparent that save for the referral by the Urology team to the Pain Service in September 2023, there was no liaison or communication between any of the specialties involved in Mr Williamson's care, which resulted in a lack of understanding on the part of each specialty of the plans and actions of the others.<br><br>The inquest was told that there is a significant proportion of patients who are referred to the Pain Service who suffer poor mental health and who are therefore also under the care of mental health teams in the community.<br><br>The inquest heard that there is no formal framework (other than in cancer care and one specialist area of surgery) either locally or nationally to facilitate inter-specialty communication, particularly in complex and dynamic cases and further, that the existing channels of communication are more problematic between different NHS Trusts even within the same geographical area. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 14th February 2025. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely Mr Williamson's son on behalf of the family,<br>Greater Manchester Integrated Care, Manchester University Hospitals NHS Foundation Trust, Greater Manchester Mental Health NHS Foundation Trust, who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **Adrian Farrow**<br>**HM Assistant Coroner**<br><br>  <br><br>**20/12/2024** |