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** [redacted], Chief Executive (Bradford District Care NHS Trust)
1	**CORONER** I am Angela BROCKLEHURST, HM Assistant Coroner for the coroner area of West Yorkshire Western Coroner Area
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 20 February 2024 I commenced an investigation into the death of Andrea Denise MANN aged 61. The investigation concluded at the end of the inquest on 13 January 2025. The conclusion of the inquest was that: Upon the 10th February 2024, at her home address, Andrea Denise Mann was discovered by a member of her family, to be hanging from a noose placed around her neck[redacted] Mrs Mann was released from her position, and transported by the Ambulance Service to Bradford Royal Infirmary where she was admitted to the Intensive Care Unit. Despite receiving advanced life support the medical condition of Mrs Mann did not improve. Following discussions between attending clinicians and the family of Mrs Mann, a decision was made to withdraw invasive medical care, with Palliative Care then being provided to her. Sadly, the death of Mrs Mann was certified at the hospital on the 11th February 2024 at 14.44 hours.
4	**CIRCUMSTANCES OF THE DEATH** Andrea was found by her husband, hanging[redacted] Emergency services attended, CPR commenced and she was admitted to hospital. She was admitted to hospital, but sadly the following day she was weaned from the ventilator, as family felt that she would not wish to continue with ICU invasive therapy if she would not be able to return to her previous level of function. She passed away a few hours later.
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 findings made by myself at the Inquest include the following; 1) That during the period of her involvement with the Community Mental Health Trust between the period 25/04/2023 and 04/12/2023 the care given to the deceased was

	limited to 2 appointments only within which she was referred back to her GP for medication adjustment which had been seen to be ineffective, and referral to Psychological therapy sessions which had a waiting period of 6 months despite an earlier private consultation having been proved ineffective, That the frequent requests of the deceased and her family for a Psychiatric appointment had not been provided to her, with the result that the deceased had to seek a private consultation. 2) That no evidence of any overarching management tool existed to provide scrutiny of the care given to the deceased, or measure the success or efficacy of such care, and as such there were many lost opportunities to provide to the deceased and her family sufficient, consistent, controlled and bespoke care.
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 April 29, 2025. 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 **Bradford Mental Health - BDCT** I have also sent it to [redacted] who may find it useful or of interest. 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: 06/03/2025** Angela Brocklehurst **Angela BROCKLEHURST** **HM Assistant Coroner for** **West Yorkshire Western Coroner Area**


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