REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Part 1** 1. **Somerset Foundation Trust** of Trust Management Office, Level 1, Yeovil District Hospital, Yeovil BA21 4AT **Part 2** **1. Somerset Foundation Trust** **2. Royal College of Obstetricians and Gynaecologists of 10-18 Union St, London SE1 1GH** **3. Royal College of General Practitioners of 30 Euston Square, London NW1 2FB** **4. NHS England of Wellington House, 133-155 Waterloo Road, London SE1 8UG** **5. National Institute for Health and Care Excellence, 2nd Floor Redmond Place, London E20 1JQ**
1	**CORONER** I am Samantha Marsh, Senior Coroner for the coroner 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 6th December 2022 I commenced an investigation into the death of Jacqueline Anne Potter, aged 54, (known as "Anne"). The investigation concluded at the end of the inquest on the 10th March 2025. The conclusion of the jury inquest was a short form conclusion of Suicide in box 4. The Jury's answer to 'when, where and how' was recorded in box 3 of the Record of Inquest as follows: "Anne was a 54 year old menopausal woman experiencing a number of stresses in her life. The menopause contributed to her mental health decline and exacerbated her underlying anxiety. On the 27th September 2002, Anne took an overdose of paracetamol. She was taken to Yeovil District Hospital where she received treatment. She then received daily community mental health support. After found wandering in traffic and absconding from her home, on the 20th October 2022, she agreed to a voluntary admission to Rowan Ward. She was then detained on a section 5(2) of the Mental Health Act. On the 21st October 2022 this was upgraded to a section 2 detention. On the 24th October 2022, she was granted her first Section 17 Leave. On the 31st October 2022, on a walk with a Health Care Assistant, Anne attempted to run into the

	road. On the 16th November 2022, due to a number of incidents and no possible community support options, she was upgraded to a Section 3 detention. During her review on the 29th November 2022, Anne was authorised for Section 17 Leave for an overnight stay at home on the 4th December 2022. On the 3rd December 2022 she had a day with her family in Bristol. On the morning of the 4th December 2022, following staff assessment of Anne, the overnight leave was granted. Anne's family did not receive appropriate information to assist them in keeping Anne safe for an overnight stay. She went home on the 4th December 2022 and in the morning of the Fifth December 2022 Anne used a key to open the back door, took a car key and drove away. Anne was driving on the Eastbound carriageway of the A303 and at 07:48 she deliberately drove into the path of a HGV tank lorry on the opposite carriageway." The medical cause of death was recorded as: Ia) Multiple traumatic injuries
4	**CIRCUMSTANCES OF THE DEATH** Anne first presented to her GP in 2008. During this year she had three separate appointments relating to underlying anxiety and being unable to cope. There was no secondary mental health service involvement, nor was there any prescription of anti-depressants at this time. Anne presented to the GP again in 2014, so six years later. Her presentation at this time was felt by the GP to be a grief/bereavement reaction. From early 2017 up to the end of 2019 there were five separate consultations for gynaecological and/or gastroenterological presentations but despite secondary investigations, no underlying physiological cause was found and the GP felt that there was a high possibility that her tummy and bowel issues were related to her underlying anxiety. On the 18th December 2020, Anne had her first significant consultation about mental health symptoms. She was extremely anxious and low in mood and stressed with life in general. On the 11th January 2021 Anne was emotionally fragile, anxious and stressed. This was the first consultation at which menopause (or perimenopause) was mentioned. Given her presentation it would appear that her underling anxiety had been slowly building; possibly since 2008 but much more so since 2017. Anne started taking Sertraline in February 2021 (she was prescribed this in the January but was too anxious about side effects to start taking it). She was also started on HRT. By the end of May 2021 her symptoms appeared to be under control but it was impossibly to know if this was the Sertraline, the HRT or a combination of both. In July of 2021, following consultation with her GP, the dose of Sertraline was titrated down so that by the Autumn of 2021 she had stopped taking this medication altogether. In early September 2022, Anne's presentation declined again and she agreed to re-start Sertraline. On the 27th September 2022 Anne was at home with her husband when she informed him she'd taken [redacted] tablets. This was the first time Anne had done anything like this before and it was very much the start of her acute decline. After discharge from hospital she was seen daily by the mental health team, and declined an admission. On the 20th October 2022, Anne did agree to a voluntary admission to an acute psychiatric unit. This was after she had been returned home by the police who responded to a member of the public who had called in after finding her wandering in traffic. Anne was detained under section 5(2) of the Mental Health Act. She remained detained up till the date of her death; being placed on a Section 2 detention and this was upgraded to a Section 3 detention on the 16th November 2022.

	Anne had a devoted and supportive husband and family, who were keen to be involved in her care and recovery; so much so that Anne started taking section 17 leave from the 24th October 2022 (3 days after she was detained). She would take escorted leave with either the staff or her husband in the local area for a couple of hours (gradually increasing to up to 6 hours at a time). On the 31st October 2022 whilst out with staff Anne ran into the road and was pulled back by the Health Care Assistant. It was never established what Anne was actually trying to do on this occasion; whether she was trying to harm herself or whether she was simply trying to avoid going back to the ward as she did not like the ward environment and had said that she would rather be at home with her husband. She remained on the ward without leave for three days after this incident. On the 29th November 2022 an MDT (Multi Disciplinary Meeting) took place. At this meeting section 17 overnight leave was authorised for the 4th December 2022 on the basis that there had been no incidents of risky behaviour and/or absconding (with the exception of the 31st October 2022) and since that incident leave between the 4th and 29th November 2022 had gone 'well'. Both Anne and her husband were keen for overnight leave and it was felt entirely appropriate to support this wish as part of her recovery. Anne went out for 6 hours on the 3rd December 2022 to a Christmas market in Bristol with her husband. This leave went well and without incident. Anne appeared brighter; she was showing future planning with her family for the forthcoming Christmas period and was commenting on finding pleasure and enjoyment in things again (the mental health team highlighted her enjoyment at watching Strictly Come Dancing which whilst small, highlighted a departure from her previous anhedonia). Anne was assessed by a mental health nurse prior to her overnight leave on the 4th December 2022. There were no concerning or alarming features or presentation that would have given the nurse (or the entire mental health team involved in her care) any clinical reason to withhold her planned leave. The entire treating team were all very clear that there was no reason to not "let her out" that day. Her husband came to collect her at just after 10am that morning. He was not given any formal or codified 'Risk Assessment' document, but he had been very heavily involved in his wife's care and treatment every step of the way and so the evidence was clear; even if he had been given such a document it would not have contained any information or details that wasn't already within his knowledge. Overnight the leave appeared to go well. Anne's husband had locked the doors and windows and hidden those keys in a desk drawer. He did not hide the car keys as he did not think for one minute that his wife would take the car. That morning Anne found the back door key in the desk drawer and took the car. She was seen driving erratically by multiple other road users who were travelling eastbound on the A303 that morning. At around 07:48 Anne drove her car into the path of a fully laden HGV tanker travelling on the westbound carriageway. There was nothing the tanker driver could have done to avoid the collision. Anne died instantly of multiple traumatic injuries. It came to light after Anne's death that she had been using her own personal device (mobile or tablet) to access websites pertaining to self harm. It is unknown whether she had accessed the psychiatric unit's wifi or whether she had made searches using her own personal data from her phone provider contract.
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. –

Part 1

(1) Anne was not sent home for her first overnight leave with any codified 'Risk' and 'Safety Planning' document. Whilst it was widely accepted *in this case* that Anne's husband was well versed and knowledgeable about his wife's risks and the measures that might be necessary to help keep her safe whilst she was at home, not all families are as involved in their loved one's psychiatric care, despite the Trust following the Triangle of Care principles.
Whilst families are not mental health practitioners and are not expected to adopt that role within the community there appears to be an opportunity to supply families with a short, codified document dealing with salient points of risks and safety planning when a patient goes for their first overnight leave since being detained. This may equip families with the knowledge to spot signs of declining mental presentation and/or risk and provide them with the knowledge and/or tools to take appropriate steps to assist in safeguarding their loved ones whilst they are in the community.
This concern (and any action deemed appropriate by the recipients of this PFD) is not intended to override autonomy of the patient and their own ability/responsibility to keep themselves safe, but the concern centres around their being an opportunity to assist families in spotting early warning signs that 'something is wrong' and to seek help and intervention (if/when appropriate) to minimise the risk of a patient taking their own life whilst in the community.

(2) It transpired during the Inquest that if an in-patient (detained or voluntary) accesses the secure unit Wi-Fi there are no algorithms or 'search detection features' to prevent access to websites pertaining to self harm and so these can be readily accessed by a group who are already vulnerable due to their acute mental health presentation with some element of inherent risk of suicide. It was noted, quite rightly, by legal representatives that workplace organisations can block access to certain sites they deem it undesirable for their workforce to access (such as sites relating to gambling, sexually inappropriate content etc) which shows that it is possible to limit access to certain websites and content when using a Wi-Fi provider. By allowing an already vulnerable group to have unfettered access to websites dedicated to self harm creates a risk of further deaths.

Part 2

(3) I am (and remain, having previously issued a PFD in a similar vain on the 26th June 2024) concerned about the lack of 'importance' given to menopausal care available to women on the NHS; especially when compared to private sector meaning that women who are not fortunate enough to be able to access private clinics and facilities may not be able to access the services and expertise they need at a very crucial transitional phase in their lives. Menopause is not a lifestyle choice, it is an unavoidable part of a woman's natural biological cycle. Without wishing to introduce sweeping generalisations, menopause is likely to affect 50% of the population at some point in their lives [according to Statistics Times, women made up 50.75% of the UK population in 2024].

I am concerned that:

(i) Certain elements of medicine and clinical practice training are compulsory but having heard evidence at the Inquest around mandatory and statutory

	training modules I learnt that this covers areas such as GDPR training and disposal of sharp objects such as syringes. I was surprised to learn that menopausal training is not mandatory in <u>any</u> area of clinical practice or specialism. I am concerned that there is no requirement to undertake essential compulsory menopausal training for those working in 'relevant' clinical practices such as Mental Health Practice, Obstetrics and Gynaecology and Oncology, or even general as a general GP. (ii) I was told that the Trust has just one 'menopause specialist' (a GP) who covers the entire Trust operations. Not all GP surgeries have a menopause specialist practitioner (or access to one) despite a GP usually being the first port of call for women in the community when seeking primary care. Those GP Surgeries who do have a practitioner who acts as a 'specialist' is often a GP with a personal interest who has taken the initiative to go on courses and broaden their learning and understanding, rather than any mandatory requirement for a Surgery [or group with multiple surgeries] to have an available community 'front-line' specialist. I was told that the Trust does not have an "expert" in this field and it would be difficult to have one as menopause isn't a disease or an illness. Whilst I do not dispute that is it not a disease, menopause **<u>is</u> a *condition***; it does have *symptoms* and it does have *recognised presentations,* yet there appears to be a failure to recognise this condition as having equal importance to other ailments or diagnoses. I was told during a previous PFD Response relating to menopausal knowledge and care within the NHS that "It is important to ensure that women understand common symptoms such as anxiety, stress and depression which they might experience during the menopause and where and when to seek help. *The NHS website has resources*…." This emphasises my concerns entirely; the lack of importance given to menopausal symptoms. If someone has concerns about heart disease, a worrying lump, a broken bone etc they expect to be able to consult a medically qualified professional who has a knowledge and understanding of their condition or presentation and can diagnose and treat accordingly; not just [and I paraphrase] 'have a look at a website to help'. I appreciate that each and every woman will experience perimenopause and menopause differently, their individual experience is unique to them and this, to some degree, creates difficulties as a 'one size fits all' approach (which is perhaps achievable in other medical specialisms and disciplines) cannot be offered, but the lack of recognition of the importance of this condition remains a significant concern. I had previously been told (back in a 2024 PFD response) of a roll-out of specialist menopausal care and upskilling of GPs but there was little evidence during the inquest that this has happened/is happening and women continue to approach and navigate the menopause without the support of expert clinicians or practitioners who <u>understand and can treat the symptoms they are experiencing.</u>
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 **19th June 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: (i) Anne's family I have also sent it to the following who may find it useful or of interest. • The Menopause Charity • The British Menopause Society • Balance, Menopause 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	 **24th April 2025**