REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The Chief Executive, Pennine Care NHS Foundation Trust

CORONER

I am Chris Morris, Area Coroner for Greater Manchester (South).

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

INVESTIGATION and INQUEST

On 22nd May 2025, an inquest was opened by Alison Mutch OBE, Senior Coroner for Greater Manchester (South) into the death of Linda Fury who was found dead at home on 3rd May 2025 aged 62 years. The investigation concluded with an inquest which I heard on 12th and 13th January 2026.

A post-mortem examination determined Linda died as a consequence of hanging.

At the end of the inquest, I recorded a narrative conclusion, finding that Linda completed suicide having been unsafely discharged from hospital without provision for step-down care.

CIRCUMSTANCES OF THE DEATH

Linda Fury was found to have died at home on 3rd May 2025 having suspended herself by the neck with a ligature with the intention of causing death.

Linda had a long history of severe and enduring mental illness and had been diagnosed with bipolar affective disorder. Linda had been admitted to hospital on numerous previous occasions and was under the care of the Community Mental Health Team.

Following a significant deterioration in Linda's presentation which included what members of her treating team regarded as self-neglect and the formulation of plans to end her life, Linda was admitted to Taylor Ward at Tameside General Hospital on 11th April 2025 under s2 Mental Health Act 1983 (as amended) as no beds were available more locally.

In hospital, Linda took medication under supervision and participated to a limited extent in ward-based activities whilst consistently voicing her wish to be discharged. Linda was granted limited s17 leave but did not make use of this. Family members sought to convey their concerns that Linda was not getting better and would remain at risk if not in hospital.

At a ward round on 28th April 2025, the multidisciplinary team determined there was no longer any justification to continue Linda's detention under the Mental Health Act 1983 (as amended) but in doing so failed to:

1. Seek the views of her usual consultant
2. Substantively involve Linda's Care Co-ordinator in discharge planning throughout the admission
3. Critically consider and evaluate what Linda was telling them in the light of collateral information provided by family members and contained within medical records as to her most recent deterioration and previous instances of non-compliance with medication in the community
4. Speak with family members privately to fully understand their concerns
5. Consider utilising a period of home leave under s17 Mental Health Act 1983 (as amended) to inform whether or not detention remained indicated under legislation and
6. Acknowledge that Linda was unlikely to agree to any step-down care in the event the section was rescinded.

As such, the section was rescinded, and Linda was discharged from hospital in circumstances which were unsafe.

Upon discharge, Linda returned to the care of the Community Mental Health Team and her Care Co-ordinator reviewed her within 72 hours of discharge on 30th April 2025 to discuss care and safety planning. Whilst the Care Co-ordinator considered Linda appeared positive and denied any active suicidal thoughts, family members remained concerned that she was not attending to even basic self-care once out of hospital. On 2nd May 2025, this was communicated by e-mail to a member of Trust staff who promptly notified the Care Co-ordinator who in turn endeavoured to speak to Linda who was unwilling to speak with her and sought to speak to Linda's usual consultant who was unavailable. No further Mental Health Act assessment took place prior to Linda's death.

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. In view of the importance of robust NHS investigations in preventing future deaths undertaken from the perspective of seeking to derive as much learning as possible, I am concerned the Trust's investigation in this case was insufficiently rigorous or probing given:
    a. It has not focussed in any detail on the consequences arising for Linda (in terms of continuity of care and more broadly) as a result of the fact that no bed was available for her locally;
    b. The investigation does not undertake any meaningful critical analysis of the decision-making process which resulted in her section being rescinded and her therefore

being discharged notwithstanding family concerns in circumstances where no s17 leave had first been trialled; and

c. In respect of findings made in relation to the care provided on the day before Linda's death, it remains unclear even after hearing all of the evidence how the investigators concluded (at page 24 of 44) '[t]here was no reason to doubt Linda's capacity at this stage' in circumstances where the Trust was on notice she not attending to self-care, barely eating or drinking and refusing to speak with or see her Care Co-ordinator.

2. I am concerned that the current processes for ward rounds do not routinely facilitate an opportunity for family members to disclose any concerns relevant to risk privately to the multi-disciplinary team.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by **17th March 2026** 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, together with members of Linda's family and Greater Manchester Integrated Care Board and the Care Quality Commission who may find it useful or of interest.

The Chief Coroner may publish either or both in a complete or redacted or summary form. She 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.

Dated: **20th January 2026**

Signature: Chris Morris, Area Coroner, Manchester South.