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 Chief Executive, Greater Manchester Mental Health** **2 Chief Executive, Greater Manchester Integrated Care Partnership**
1	**CORONER** I am Timothy William BRENNAND, Senior Coroner for the coroner area of Manchester West
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 04 August 2025 I commenced an investigation into the death of Micheala FINCH aged 59. The investigation concluded at the end of the inquest on 03 February 2026. The medical cause of death was: 1a Combined drug toxicity The conclusion of the inquest was a narrative conclusion – Michaela Finch died as the consequence of an overdose of her prescribed anti-depressant medications in circumstances where her actions and intentions remain unclear in the context of a recent and acute deterioration of her mental health driven by emotional dysregulation, disordered thinking, impulsivity and relapse into recent self-induced intoxication with associated intentional non-fatal overdose.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a medical history that included mixed anxiety and depression with associated alcohol dependence syndrome. Her condition had been actively managed my local addiction, primary and secondary mental health services, and her general practitioner. Her relapse profile included recourse to chronic alcohol misuse as a coping strategy to her episodic emotional dysregulation resulting from social stressors, her physical health concerns and personal circumstances. Such relapses had previously involved inadvertent self-harm by way of overdose of her prescribed medications, with transient self-harming ideation. She had twice previously undergone inpatient detoxification and rehabilitation and had also required active phases of support from her local Home-Based Treatment Team. On the 26th of July 2025, following heightened anxiety and depression because of recent social stressors, the deceased had relapsed into alcohol misuse. In the morning of the 28th of July 2025, the deceased was admitted to Royal Albert Edward Infirmary, Wigan following an inadvertent overdose of her Zolpidem medication. She did not wish to engage in a full mental health assessment but agreed to a referral to the community mental health team and then self-discharged. Later in the day, she was to re-present at the hospital, with symptoms of further deterioration in her mental health and self-induced alcoholic

intoxication following concerns for her welfare during a prolonged attendance at her residence by paramedics.
She was referred to the Mental Health Liaison Team by reason of her suicidal ideation and following a 30-minute assessment by a mental health practitioner, was assessed to have full capacity. During her assessment, the deceased disclosed that she had recently been involved in incident with a family member in circumstances that created a safeguarding referral. However, the full nature of her mental health deterioration and emotional dysregulation, her irrational recent behaviour was not appreciated to be a significant mental health deterioration, it being evaluated to be more attributable to her recourse to alcohol misuse - and so she was discharged from hospital with a conservative community-based care plan.

It was considered that she did not meet the threshold for deployment of escalated home-based treatment. Whether this clinical decision had a bearing upon the outcome cannot be established.

As part of the response to the safeguarding alert, on the 31st of July 2025 the deceased was arrested and questioned by Greater Manchester Police. She was assessed as being fit for interview and was released after accepting a caution.
On the 3rd of August 2025, following concern for her welfare, relatives and emergency services attended her residence at 4 Belvedere Road, Ashton-in-Makerfield where the deceased was discovered in a collapsed and unresponsive condition in the lounge, being verified as dead and beyond attempted resuscitation by attending paramedics.

The deceased's postmortem samples revealed the presence of [redacted] at concentrations of medium toxicological significance, and alcohol and [redacted] at levels of low toxicological significance. CCTV footage at her residence confirmed that she had been at her home from the 1st of August 2025, her phone last being used on the 2nd of August 2025.

The evidence could not establish with precision the amount, order, time or circumstances of her self-administration of the substances found within her samples, and whilst not of themselves individually fatally toxic, in combination together, were sufficient to have brought about respiratory depression and thereafter loss of consciousness in which she suffered hypoxic driven multi-organ failure, death occurring on the 2nd of August 2025.

From within her residence, police discovered an undated handwritten note of intent, but the evidence revealed several contra-indicators to active suicidality in addition to anecdotal evidence of her recent descent into dysfunctional, irrational and unpredictable behaviour bordering on paranoia, therefore the issue of whether her actions were deliberate and intentional were established to be equivocal.

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)

1. The deceased had a well established diagnosis of mixed anxiety and depressive disorder and profound alcohol dependency syndrome – in evidence, it was established that there was no recent documented mental health diagnosis, and that it was possible that the deceased ought to have been considered as suffering from 'co-occurring disorder' (formerly 'dual diagnosis') and so eligible for a more active treatment and care escalation pathway, including a care co-ordinator.

2. An experienced recovery worker gave evidence to the effect that addiction services in Wigan receive a significant number of referrals of service users who are suffering from

	ongoing mental health issues that may require a care programme approach because they are suffering from possible co-occurring disorders and that the mental health element of treatment and care is insufficient to meet the needs of the patient – the perception being that a referral to addictions services is being used as an interim means to deal with a cohort of service users with nuanced or even as in this case - complex needs. 3. Neither the treating mental health clinician who last assessed the deceased before her death, nor the author of Rapid Review of Care Report identified the missed opportunities to appreciate the full extent of the deceased's mental health deterioration, nor the potential differential 'co-occurring' diagnosis, nor a meaningful consideration of a referral to the Home Based Treatment Team. 4. The evidence established that at least two family members had brought to the attention of a member of the Mental Health Team their profound concerns, their recent lived experiences with the deceased that underpinned these concerns, their views that the deceased was paranoid, at greater risk to herself – but none of these concerns were brought to the specific attention of the assessing clinician – the communication between the Mental Health Team and family members being sub-optimal. 5. The evidence established a potential lack of professional curiosity and confirmation bias as to the aetiology of the deceased's relapse profile – her recourse to alcohol misuse not being evaluated to be a consequence of mental health deterioration. 6. Both her last treating mental health practitioner and the author of the Rapid Review stated that there are funding issues that affect their ability to deploy escalated interim home based/community care for patients who do not qualify for voluntary/involuntary in patient assessment, or Home Based Treatment Team referral – there was stated to be no mental health equivalence of 'hospital at home' afforded to patients with a physical health condition. 7. The evidence established confirmation of a significant incidence of patients suffering from self-harm or attempted self-harm in the immediate or short term following purported assessment and discharge after interface with the Mental Health Team based at the Royal Albert Edward Infirmary – including self-discharges because of the challenging environment with the Accident & Emergency Department. 8. The evidence raises implications for patient safety, correctness of diagnosis, risk assessment and management, safe discharge and appropriate follow-up.
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 03, 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons **Family** **Kumar Family Practice**

	I have also sent it to **Chair, Wigan Local Medical Committee** 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: 06/02/2026** [redacted] **Timothy William BRENNAND** **Senior Coroner for** **Manchester West**