REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Unity Healthcare** **2. Dr [redacted]**
1	**CORONER** I am Daniel SHARPSTONE, Assistant Coroner for the coroner area of Suffolk
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 the 3rd March 2026 I opened an Inquest into the death of Melanie Ruth Pinnell. She was 57. The Medical cause of death was given as: 1a) Hanging 2 Depression The conclusion was suicide contributed to on the balance of probabilities more than minimally by non-prescription of Sertraline 50mg once a day recommended by a psychiatrist approximately two months prior to her death, and absence of mental Health input following a mental health consultation approximately two months prior to her death.
4	**CIRCUMSTANCES OF THE DEATH** Melanie had a history of depression from at least 2004 Her mental health had recently deteriorated secondary to several social stressors She had a Consultation with a GP on 10/2/25 stating that: 'Every so often she takes an 'emotional dive' can't stop crying, becomes paranoid that people are talking about her, feels suicidal. Has a couple of times had urges to act on her suicidal ideation. Struggles with anxiety all the time, low levels sensation of a knot in her stomach all the time.' Melanie had a Consultation with a Primary Care Network (PCN) Mental Health Worker on 20/2/25: She described 'feeling extremely low, feelings of despair, suicidal thoughts' This Consultation was referred to the GP. No action was taken by the GP practice The PCN worker spoke to a Consultant Psychiatrist on 26/2/25 who recommended starting Sertraline 50mg once a day. The PCN Mental Health Worker tasked the GP to relay this to the patient. This was never carried out by the GP.

	There was no follow up arranged at the GP practice following these consultations until her death on 4th May 2025 when she was found hanging at home. She had left a final note.
5	**CORONER'S CONCERNS** During 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 these circumstances it is my statutory duty to report to you: **MATTERS OF CONCERN** No follow-up was offered to Melanie by the GP practice after February 2025 despite Melanie describing suicidal ideation and suicidal thoughts The request for Sertraline 50mg once a day given by a Consultant Psychiatrist to the Primary Care Network Mental Health Care Worker was not actioned by a GP working for Unity Healthcare Both pose a significant risk to patient safety.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths as detailed above, and I believe you or your organisation have the power to take any such action you identify.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by May 15, 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: 1. Melanie Pinell's next of kin 2. NSFT I am under a duty to send the Chief Coroner a copy of your response. 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 she believes may find it useful or of interest. You may make representations to me, the Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Dated: 26/03/2026**  **Daniel SHARPSTONE**

	Assistant Coroner for Suffolk