REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Sarah Murphy, Assistant Coroner for the coroner area of Cheshire.
2.	**DATE OF REPORT** **2.7.26**
3.	**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.
4.	**THIS REPORT IS BEING SENT TO** 1. Secretary of State for Health & Social Care 2. Grove House Medical Practice You are under a duty to respond to this report within 56 days of the date of this report, namely by August 27, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6.	**SUMMARY OF CORONER'S CONCERN** 1) There are long waits for diagnostic ADHD assessments.

	2) There are large backlogs of outstanding ADHD assessments. 3) There is a significant increase in referrals for ADHD assessments. 4) Staff levels have not increased to meet the additional demand, which is impacting on waiting ties for routines and expedited ADHD diagnostic assessments. 5) There is an absence of NICE guidelines for the ADHD referral process or expedited ADHD assessments. This may lead to an inconsistent approach and different waiting times for a diagnostic ADHD assessment across the country. 6) A letter from the ADHD service on the 19 November 2024 refusing a request for an expedited ADHD assessment due to insufficient evidence being provided within the form was not placed before a GP at the Grove House Medical Practice for review and remained in Ms Hewitt's notes. 7) Follow up appointments were not always offered after mental health consultations at the Grove House Medical Practice. 8) A "Right to Choose" option for an ADHD diagnostic assessment was not offered by the Grove House Medical Practice until the 3rd February 2026. This was almost three years after the initial referral for an ADHD assessment. At the time of the initial referral, it was known that there were long waiting times for diagnostic ADHD assessment at the local NHS ADHD clinic.
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** On 23 February 2026 I commenced an investigation into the death of Bethany Kate HEWITT aged 34. The investigation concluded at the end of the inquest on 02 July 2026. The conclusion of the inquest was that: Bethany Hewitt was found hanged [redacted] The question of intent remains unclear.
9.	**CIRCUMSTANCES OF DEATH** On the 22 February 2026, Bethany Hewitt was found hanged [redacted] She had been referred for a diagnostic ADHD assessment to the local ADHD service by the Primary Care Mental Health Team on the 16th February 2023. The assessment had not been completed at the time of Ms Hewitt's death. At the

time of the referral, it was known that there were long waits for an ADHD assessment.

On the 31st October 2024, Ms Hewitt attended a GP appointment at the Grove House Medical Practice, Runcorn, where she reported that she had been referred for an ADHD assessment in February 2023 and was struggling with tasks and that it was affecting almost everything. A request for an expedited ADHD assessment was completed by a GP on the 6th November 2024.

On the 19th November 2024, a letter was sent to the GP surgery from the ADHD service stating that the expedited request had been rejected due to insufficient evidence provided within the expedited assessment request form. The letter was not referred to the GP who had requested the expedited ADHD diagnostic assessment, and it was not placed before any other GP.

There were subsequent missed opportunities at GP consultations to have discovered that the request for an expedited ADHD assessment had been rejected on the 19th November 2024. Consideration could then have been given to further reviewing Ms Hewitt for a further request for an expedited ADHD assessment.

Ms Hewit attended subsequent consultations relating to mental health issues where follow up reviews had not been requested by the GP. In particular, consultations on the 6th November 2025 and the 3rd February 2026.

At the consultation on the 6th November 2025, Ms Hewitt advised that she felt that her ADHD symptoms were worsening, she reported that she was very anxious and was noted to be tearful in the consultation. She was started on 25mg daily Sertraline and was advised that a side effect of this medication was an increased risk of suicidal ideation. A follow up appointment was not made despite starting this medication. There was also a missed opportunity to consider offering the “Right to Choose” option for an ADHD diagnostic assessment.

On the 2nd February 2026, the Duty Practitioner at the surgery arranged a GP consultation the following day for Ms Hewitt after she had disclosed suicidal ideation on a PHQ9 questionnaire. In the questionnaire, Ms Hewitt had reported that for several days over the last two weeks, she had been bothered by thoughts that she would be better off dead, or hurting herself in some way.

At the GP consultation on the 3rd February 2026, Ms Hewitt reported that the reasons for her responses in the questionnaires were the wait for an ADHD assessment and a worsening in perceived ADHD symptoms. It was determined that it was not clinically indicated to refer Ms Hewitt to secondary mental health services or for an urgent Mental Health Act assessment. She denied any active plans for suicide. A “Right to Choose” option was offered at the appointment. In evidence, the GP stated that this was the first time that it had been offered to Ms Hewitt.

A follow up appointment was not requested by the GP on the 3rd February

	2026, when the score from the PHQ 9 questionnaire was 15/27. In evidence, I heard that NICE Guidelines recommend an urgent referral to specialist mental health services where there is “more severe depression “ which is evidenced by a PHQ score of 16 or more. Ms Hewitt’s mental health was not monitored after the GP consultation on the 3rd February 2026, but she had confirmed that she had emergency mental health telephone numbers. It is likely that the long wait for an ADHD diagnostic assessment and a worsening in perceived ADHD symptoms contributed to the decline in Ms Hewitt’s mental health.
10.	**CORONER’S CONCERNS** During the course of the inquest I heard evidence 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: 1) Bethany Hewitt had been waiting for three years for an ADHD diagnostic assessment and had not been assessed at the time of her death. I heard evidence from the Trust that in 2024, the ADHD Service Halton had over 1,250 patients awaiting assessment, alongside high referral rates of around 100 plus per month. A process was in place to request urgent referrals to be expedited. 2) At present, the ADHD Service Halton is experiencing sustained high demand, receiving on average over 30 new referrals per week and approximately 60 expedite requests per month. Over the last two years the service has experienced a 600% increase in referrals which was in line with ADHD services nationally. I heard evidence that staff levels were impacting on waiting times for a routine and expedited ADHD assessment. I am concerned that staff levels are impacting on waiting times for diagnostic ADHD assessments and is causing significant delays. 3) I heard evidence that there are no national guidelines (NICE guidelines) in relation to the ADHD referral process or expedited assessments. I am concerned that this may result in an inconsistent approach, and that waiting times may vary across the country, with patients not knowing how long they should be expected to wait for a diagnostic assessment 4) The letter from the ADHD service on the 19 November 2024 refusing the request for an expedited ADHD assessment due to “insufficient evidence being provided within the form”, that was sent to Grove House Medical Practice, was not placed before a GP for review. It remained in Ms Hewitt’s notes. I am concerned that there is a risk that important external communication is not reviewed by GP’s at the Grove House

	5) Follow up appointments were not always offered by GP's at Grove House Medical Practice. In evidence at the inquest, a GP from the practice was unsure if there were NICE guidelines that recommend when GP's should offer follow up appointments after mental health consultations and was not aware if there was a practice policy in relation to follow up appointments after a mental health consultation. I am concerned that there is a risk that mental health is not always monitored so that timely referrals can be made to secondary mental health services. 6) The "Right to Choose" option for an ADHD assessment was not offered until the 3rd February 2026, which was almost 3 years after the initial referral for a diagnostic ADHD assessment. It was known at the time of the initial referral for a diagnostic ADHD assessment, that there were long waiting times for an assessment. I am concerned that there are missed opportunities to request an ADHD diagnostic assessment under the "Right to Choose" option which may enable an earlier assessment
11.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: *[please do not use individual's names, but instead roles/titles]* • **Family** • **Mersey Care NHS Foundation Trust** • **Solicitor for MDU** • **Solicitor for Mersey Care NHS Foundation Trust** • **Solicitor for GP's** • **Grove House Medical Practice** • **NICE** • **Royal College of Psychiatrists** I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.

12.	**SIGNATURE**  **Sarah MURPHY** **Assistant Coroner for** **Cheshire**