REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Team Manager, Trafford Crisis Resolution and Home Treatment Team (CHRTT)** **2. [redacted] Manager, Improving Access to Psychological Therapies (IAPT)**
1	**CORONER** I am Andrew Bridgman, assistant coroner, for the coroner area of Manchester South.
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 20th November 2012 an investigation was commenced into the death of Michael Stuart Irlam. The investigation concluded at the end of the inquest on 8th August 2013. The conclusion of the inquest was Killed himself whilst the balance of his mind was disturbed. Medical cause of death 1a Hanging
4	**CIRCUMSTANCES OF THE DEATH** Mr Irlam was suffering severe depression and anxiety, diagnosed mid-August 2012. He was in the care of his GP. After an attendance at A&E at Trafford General on 22nd August 2012 Mr Irlam became engaged with the CHRTT. He was visited daily initially, later reducing to alternate days. On 20th September 2012 Mr Irlam took and overdose and was admitted to Trafford General overnight. He continued his engagement with the CHRTT. He was discharged from CHRTT on 8th October 2012. He was told that IAPT would contact him by letter. Almost 2 weeks passed before a letter came. He under took a telephone assessment in order to expedite his hoped for treatment as it was quicker than having a face to face interview. He was advised to await another letter advising him of treatment. He did not get such a letter, simply a duplicate of the first letter. Mr Irlam then consulted and received treatment from a private psychologist. On 13th November 2012 Mr Irlam hung himself from the banister at his home while his wife was out. His daughter was at home.
5	**CORONER'S CONCERNS** [redacted] Senior Clinical and Forensic Psychologist was engaged to conduct a Post Incident Review & Report. That report concluded at page 31 - **'Putting the patient first - perceived gaps from the patient perspective'** that a waiting time of 24 days between discharge from CRHTT and the first appointment with IAPT could not be construed as a delay. This issue that arose at the Inquest hearing was the potential for a feeling of abandonment because of the discharge without any knowledge of how long it would be

	before the next contact; of having to wait for the next stage/step without knowing when that would be. Mrs Irlam was clear that her husband deteriorated over this period despite the close, and loving, support provided by her and their family. That her husband found this a most distressing and difficult time. Even if the Review Panel do not consider a waiting time of 3 weeks plus to be a delay for someone with mental health issues I take the view that a waiting time of 2 weeks without knowing the next contact for help/treatment will be is not appropriate.. My concern is for the welfare of other patients who will fall into this gap between treatments/counselling who, unlike Mr Irlam, do not have a close and supportive family and the effect on them. During the course of his evidence [redacted] explained that the two organisations were working closer together administratively. He was not, however, able to respond to my line of enquiry as to why a patient could not be given an appointment with IAPT on discharge from CHRTT. My concern is this. It seems to me most important and appropriate that a vulnerable patient with mental health issues ought not to be exposed to a feeling of abandonment, likely to lead to a deterioration in their condition, and that they should (where possible) be given an appointment with IAPT on discharge from CHRTT, if that is the agreed next step. That would also deal with the issue that upon receipt of the awaited letter from IAPT the patient has to be proactive to engage the referral to IAPT. 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) That if a follow-up with or referral to IAPT (or any other organisation) is deemed appropriate upon discharge from CRHTT then such an appointment should be arranged before or upon discharge. (2) (3)
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your respective organisations 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 17th October 2013. 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. I have also sent it to [redacted] wife of the deceased, who may find it useful or of interest. I am also 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. 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	**[DATE]** 4/9/13 **[SIGNED BY CORONER]**