REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **5 Boroughs Partnership NHS Foundation Trust**
1	**CORONER** I am Joanne Kearsley, Area Coroner, for the coroner area of South Manchester
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 6 May 2014 I commenced an investigation into the death of Roseanne Cooke – date of birth 20.05.1958. The investigation concluded on the 27th October and the conclusion was one that the deceased had taken her own life. The medical cause of death was recorded as 1a) Hanging
4	**CIRCUMSTANCES OF THE DEATH** I heard evidence that the deceased had, over a relatively short period of time, had a marked deterioration in her mental health – a prominent feature of which was suicidal thoughts. She had been an inpatient on the Sheridan Ward in January 2014 until her discharge on the 7th February 2014. On the 26th February she then re-presented having taken an overdose and was then transferred to the Grasemere Unit at Whiston Hospital due to a shortage of beds. She remained an inpatient and was transferred back to the Sheridan Ward on the 9th April. A week later on the 17th April 2014 she was discharged home under the care of the Home Treatment and Recovery Teams. On the 1st May 2014 the deceased was found having taken her own life at her Mother's home.
5	**<u>CORONER'S CONCERNS</u>** 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. – - It was clear from the evidence that the deceased required psychological input. The Inquest heard evidence that whilst she was an inpatient on the Grasmere Unit there was no inpatient psychological input available due to maternity leave which had not been covered. - There was confusion in the evidence as to whether, whilst an inpatient on

	Grasmere, a referral had been made to outpatient psychological services (i.e. the Recovery Team services). This resulted in a referral being made by her Care Co-ordinator on the 24th April when she had been already been discharged home. This confusion meant that there was either a delay in any referral being made or at best a duplication of her referral. - On the 17th April there was a meeting which ultimately led to the discharge of the deceased from hospital. The Care Co-Coordinator had already expressed that she would not be available due to annual leave but had left details of her colleague who would attend if this was a discharge planning meeting. No-one from the Recovery Team attended this meeting. They were the prime carers for the deceased on her discharge and had the role of Care Co-ordinator. - On the 28th April, the deceased's family contacted the Home Treatment Team out of hours numbers available to them as they had concerns about the deceased being in the house on her own the following day as she was having suicidal thoughts. Their understanding of the request was that someone from the Recovery Team would visit her the following day. The message passed to the Recovery Team was simply to make contact with the deceased, which was done over the phone. The extent of the concerns raised by the family was not communicated to the Recovery Team.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 5 January 2015. 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 namely [redacted] I have also sent it to Greater Manchester Police 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: 10 November 2014** **Joanne Kearsley, HM Area Coroner Manchester South**