REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Manchester Clinical Commissioning Group** **Parkway 3** **Parkway Business Centre** **Princess Road** **Manchester** **M14 7LU** **Manchester Mental Health and Social Care 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 the 10th April 2014 I commenced an investigation into the death of Rowena Kathryn Golton, date of birth 26.02.1969. The investigation concluded on the 15th August 2014 and the conclusion was one that the deceased had taken her own life. The medical cause of death was 1a) Multiple Traumatic Injuries.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a history of recurring depression which became more pronounced from August 2013 onwards. She had attended at her GP surgery initially and then in January 2014 had seen the mental health services. A recurring feature throughout her presentation was suicidal thinking. The deceased had a period of inpatient admission and subsequent involvement of the crisis team. There was clear evidence that the deceased needed longer-term psychological therapy. A referral had been made but due to the length of the waiting list she had not been seen. On the 6th of April 2014 the deceased jumped from the fire escape at the top of Vernon Mill in Stockport. At the time of her death she was suffering from deterioration in her mental illness. In the early hours of the 6th of April the deceased had presented at the A&E Department at Manchester Royal Infirmary having been brought back from abroad by her mother who had travelled to collect her following her admission to hospital in Morocco as a result of her mental illness. She was assessed as a low risk of suicide and discharged with a plan for her to be seen later in the day on the 6th of April by the crisis team.

5	**CORONER'S CONCERNS** 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. – - Evidence was given as to the lack of availability of psychological services within the crisis teams. Following her admission as an inpatient she was then under the care of the crisis team. Not all crisis teams have access to a psychologist and the internal investigation recognised that there needed to be a review of the availability of psychological services to ensure adequate provision and access. - In addition there was recognition that the waiting times for access to psychological therapy are significant and there is a greater need for the service to prioritise cases.
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 6 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 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: 11 November 2014** **Joanne Kearsley, HM Area Coroner Manchester South**