REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Secretary of State for Health, Department of Health, London
1	**CORONER** I am Ms L J Hashmi, Area Coroner for the Coroner area of Manchester North.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 5th December 2014, I commenced an investigation into the death of Ms Janette Insley.
4	**CIRCUMSTANCES OF DEATH** The Deceased had a longstanding history of depressive illness. In May 2014 her mental and psychological health deteriorated markedly resulting in her admission to a mental health unit as an informal patient. She declined pharmaceutical intervention on the basis that she believed she was suffering from Protracted Withdrawal Syndrome and that medication was responsible for her signs and symptoms. The doctors caring for the deceased did not share this view, their diagnosis being that the deceased was suffering from traits of personality disorder and an inability to cope with psychosocial stressors. They felt that there was no evidence of a biological depressive disorder during the course of the index admission. Upon this basis, the hospital doctors considered that referral to a Psychologist for care and treatment was the most appropriate course of action. Discharge planning was commenced and halted on several occasions due to episodes of serious self-harm by the deceased, including attempts at self-ligature and overdose. During the course of her inpatient stay, the deceased was allowed time off the ward/leave away from the ward, subject to risk assessment by care staff. On the whole, whilst very stressful for the deceased, the periods of leave passed without incident. However, on the 3rd August 2014 the Deceased failed to return to the ward following afternoon home leave. Enquiries were made by ward staff and the deceased's ex-partner/friend in an attempt to make contact. Ms Insley was subsequently found deceased at her home address later that evening, having self-ligatured.
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:- 1. During the course of the evidence I was told that whilst the Consultant Psychiatrist considered that a referral to a Psychologist was the most appropriate course of treatment

	available, staff were unable to make any such referral for inpatients due to lack of i) availability of suitably qualified practitioners and ii) resources. There is therefore a clear service gap. 2. I was also told that most, if not all, Psychological therapy now takes place within the community. It would appear that undue emphasis is currently being placed upon this setting of care, to the detriment of inpatient services. 3. That any referral to/consultation with a Psychologist based within the community would have taken at least 3-4 weeks post-discharge, thus leaving the patient without therapy during a particularly vulnerable period.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 11th February 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:- - The Deceased's family - Pennine Care NHS Trust - CEO, Bury CCG 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 from. 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: 16th December 2014 Signed: