REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Secretary of State for Health, Jeremy Hunt, House of Commons, London SW1A 0AA
1	**CORONER** I am M Jennifer Leeming, Senior Coroner for the Coroner Area of Manchester West
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 3rd of January 2014 I commenced an investigation into the death of Helen England, aged 38. The investigation concluded at the end of the inquest on the 7th March 2016. The conclusion of the inquest was Suicide.
4	**CIRCUMSTANCES OF THE DEATH** Helen England has suffered from Bipolar Affective Disorder since 1999 and between that time and her death she had been detained as an in-patient under the terms of the Mental Health Act on eleven occasions. On the 15th October 2013 Helen England was discharged from an in-patient compulsory admission to Leigh Infimary that had been imposed under the terms of the Mental Health Act. On the same date she was made subject to a Mental Health Act Community Treatment Order containing certain conditions. Whilst living in the community subject to the order Helen was subject to social stresses and her mental health deteriorated. Her behaviour also gave rise to a concern that she was a risk to others. On the 18th November 2013 she was re-admitted to Leigh Infirmary and was subsequently again detained as an in-patient under the terms of the Mental Health Act. On the 13th December 2013 Helen was again discharged from hospital and a second Community Treatment Order was imposed. Whilst in the community Helen again became subject to social and relationship stresses as had previously happened. On the 22nd December 2013 Helen was admitted to The Royal Albert Edward Infirmary in Wigan, having self-inflicted a superficial cut to her left wrist and a deep lacertion to her right arm. This was the first occasion in Helen's history upon which she had demonstrably self-harmed. During the evening of 22nd December Helen was seen by a Registered Mental Health Nurse who decided that Helen was not fit for a mental health assessment at that time. There was a plan for Helen to be seen by her Community Support Worker the following day, the 23rd December 2013, but this visit was cancelled by the Community Team due to Helen's hospital admission.

	On the 24th December 2013, Helen underwent surgery for the injury to her right arm at The Royal Albert Edward Infirmary in Wigan, following which she was assessed as being medically fit for discharge at about 19.30 hours. At approximately 20.30 hours Helen was seen on the ward by the same Registered Mental Health Nurse who had previously seen her on the 22nd December. The nurse conducted an assessment of Helen's mental health in the course of which Helen denied that she had intended suicide when she had injured herself, nor did she admit to having any suicidal ideas at the time of the examination. The nurse decided that Helen did not meet the criteria for detention under the terms of the Mental Health Act and it was planned that Helen should be discharged to reside with her family for the next few days. The nurse was not required to, and did not, seek advice from a doctor when making this decision, despite Helen being subject to a Community Treatment Order. The nurse was aware that Helen was subject to the Order, but was not aware of its terms since they were not included in the records available to the nurse. There was no protocol or guidance in place for the nurse to follow when considering whether or not to refer a decision to discharge a patient to a doctor, either when a patient was subject to a Community Treatment Order or at all. Following Helen's discharge on the 24th December 2013, she did stay with her family until the morning of the 26th December 2013 when she insisted upon returning to her own home at 5 Sandy Lane Lowton. At or about 10.42 on the 26th December 2013 Helen's mother telephoned Mental Health Services to advise that Helen had returned home and to express concerns about her safety. In a second telephone call she was advised to contact the Police, but she did not feel able to do this. That call ended at about 11.12 hours. The Mental Health Nurse tried to contact Helen at about 11.36 hours and when she could not do so she first telephoned Helen's mother and then the Police at about 11.44 hours. The delay of twenty four minutes between the Nurse speaking to Helen's mother and the Nurse ringing the Police has not been fully explained. The Police call taker received the call at 11.51 hours and graded it as requiring an attendance at Helen's address within one hour, and a Police Officer arrived at Helen's home at 12.11 hours. The Officer then waited for the attendance of a second Officer before entering the property, because there was intelligence that one of the occupants of the property, who was not Helen, had previously injured a Police Officer attending at the address. A second Police Officer arrived at 12.30 hours and both Officers entered Helen's home at 12.31, where they found Helen hanging from the staircase having left notes indicating an intention to end her own life.
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) There was no protocol nor any guidance in place for Mental Health Nurses at the 5 Boroughs NHS Partnership Foundation Trust to follow when considering whether or not to refer to a Doctor a decision to discharge a patient, following an attendance at, or admission to, an acute Hospital consequent upon an episode of self-harm, particularly when the patient is subject to a Community Treatment Order imposed under the terms of the Mental Health Act.

	Evidence was given at the Inquest that such guidance will be introduced at the 5 Boroughs Trust and that it would be welcomed in similar Trusts.	
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and your organisation 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 10 May 2016. 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:- 1. [redacted], Helen's Mum 2. [redacted] Slater and Gordon Solicitors 3. [redacted] DAC Beachcroft 4. Andrew Foster CBE, CE , The Royal Albert and Edward Infimary 5. Simon Barber, CE, 5 Boroughs Partnership 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	**Dated** **16 March 2016**	**Signed** **M Jennifer Leeming**