REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Pennine Care NHS Foundation Trust**
1	**CORONER** I am Joanne Kearsley Acting Senior Coroner for 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 the 30th November 2016 I concluded the Inquest into the death of Sandra Brotherton date of birth 10.07.1954 who died on the 31.12.14 at her home address in Bredbury Stockport. The cause of death was 1a) Multiple Stab Wounds I recorded that the deceased died on the 31st December 2014 at her home address. She was killed by an individual who had a dual diagnosis of paranoid schizophrenia and Aspergers. For several days the deceased had been in hospital and the individual who had no insight into his illness at been at the home address alone. It is probable that he had not been eating, sleeping or taking his medication during this period of time and had experienced a breakthrough in his symptoms. When the deceased arrived home he was exhibiting agitated and disturbed behaviour and killed the deceased a few hours after she arrived home. Conclusion – Unlawful Killing
4	**CIRCUMSTANCES OF THE DEATH** The Inquest into the death of Sandra Brotherton was resumed following a criminal trial in which the offender, [redacted]h had been sentenced to a hospital order. There were matters of concern raised surrounding his involvement with Mental Health Services. [redacted] had a dual diagnosis of Paranoid Schizophrenia and Aspergers Syndrome. He had been sectioned many years ago for a short period of time but had subsequently been cared for at the home address by Sandra Brotherton who was predominantly his sole carer. [redacted] required prompting to do many daily tasks including washing, dressing,

eating and taking his medication.

was described by several witnesses as someone who had residual symptoms of his psychosis and lacked understanding and insight into his condition. He never accepted that he was unwell

Sandra was the focus of aggressive behaviours and we heard evidence of the arguments which might occur between them and of name calling of over many years when he called her such things as "witch and satan". Sandra as the main carer and indeed main person in life who bore the brunt of his behaviour and verbal aggression.

Package of Care in place for

The Court heard how was under the care of mental health services. He was treated with medication which was reviewed and until 2014 he was under the care of the Community Mental Health Team, EIT. This was then transferred to Recovery and Intervention Team (RIT). Under both services had a care co-ordinator. Indeed the difference on a practical level for was the change in his worker.

In addition had a Personal Assistant which was paid for through the Direct payments scheme of the local authority who had been in place since 2006.

Contingency Plans

Given that Sandra was effectively the sole carer for questions were asked at the Inquest as to a contingency plan in place should Sandra not be in a position to care for . At times the evidence on this was interlinked with the plan for respite care but overall the contingency plans for were simply having provided contact details for the Access and Crisis teams and the Home Treatment team and believing that family were close and on hand to provide support.

Information Provided to PA and interaction with Mental Health Services

confirmed it was not until after death that he was aware of diagnosis of Schizophrenia. His understanding was that Mental health services were involved because of diagnosis of autism. was clear that he received his instructions from Sandra. He had very little contact with care co-ordinator although there were occasions when he would see her. It was clear from the evidence that was included in the care plan for but as he stated in his evidence, " he would not know if he was."

The mental health team were not aware when would be on leave – the RIT Team confirmed that she would have expected that the RIT team were aware of when the PA was on leave and would have expected increased visits by the care co-ordinator during this time also accepted she could have increased her visits had she known the PA would be away.

August 2014 and Incident on the 18th September

The Court heard evidence of involvement with and Sandra throughout the August and September of 2014. In August 2014 had received a call indicating was unwell and she carried out an urgent home visit. She indicated that she could see he was unwell, he was agitated, she stated though that he was not delusional. At this stage she advised how was on leave and she spoke to another Dr who agreed to increase Olanzapine medication. The Court also heard that during this time she tried to get an urgent appointment with a Consultant Psychiatrist but this was not possible.

A month later the Court then heard evidence about the incident which occurred on the 18th September.

Sandra told her daughter that had lashed out and hit her in the face. There was also some evidence she also told her husband who was abroad but may not have told him the full details.

We know that she told her sister that had hit her, saying that had tripped and had not meant to do it, she was convinced it was a one off. Also told her sister , who felt that had crossed a line and urged Sandra to seek help. In addition she did tell that had lashed out at her but when asked, she said that she had reported it to care team.

Sandra did telephone Mental health services on the 18th September – at no stage in any of the conversations did she say that had assaulted her. We know that she did ring saying that he needed to be re-housed immediately. in her evidence described "trying to make sense of the reasons Sandra wanted out of the property" and recalled her being "vague". She recalled "it was almost as if Sandra just wanted him out of the house not that she felt at risk". Sandra was asked about risk and told who documented the same that she did not feel at risk.

December 2014

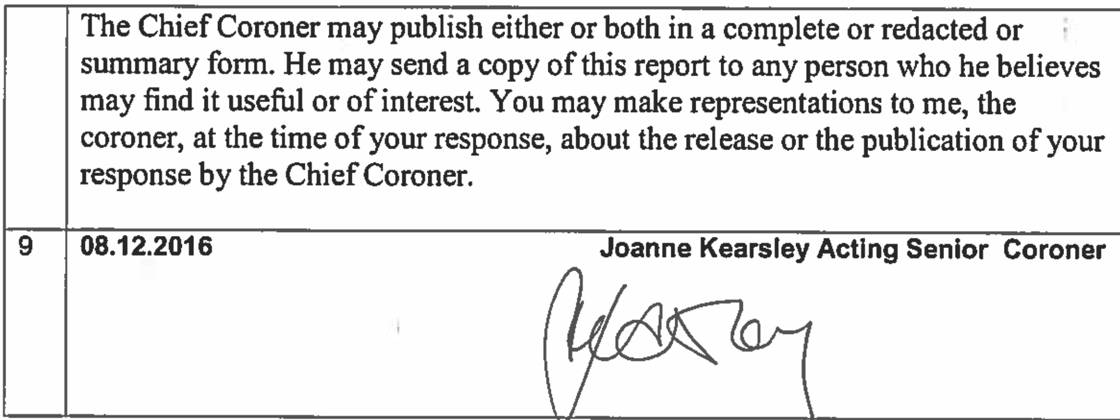
Sandra was unwell over the Xmas period and had attended hospital on the 22-23rd December. She then reattended and was admitted on the 28th December. At no stage were Mental Health services aware of her admission. When she returned home on the 31st December 2014 she was killed a short time later.

5 **CORONER'S CONCERNS**

The concerns noted by the Court during the course of the Inquest are as follows:

1) Knowing that Sandra was in effect a sole carer there should have been

	a clearly discussed contingency plan for [redacted] in the event that there was an emergency and Sandra was not able to provide care. 2) Where a Personal Assistant is integral to the Mental Health Service Care plan there should have been a clear and documented record that the care plan should be provided to them. If there is an objection to confidential medical information being shared by the relevant person, where there is no suggestion of a lack of capacity, this should be recorded. 3) It was concerning that the Care Co-Ordinator who visited [redacted] in August 2014 was not able to obtain an urgent appointment with a Consultant Psychiatrist (in what is a multi-disciplinary team) at a time when she felt an urgent appointment for someone with a dual diagnosis was required. Whilst his medication was increased at this stage he was then not seen by a Consultant until October 2014 4) Having heard the evidence as to the events of September 2014 there is no doubt that this was an unusual call to be made by Sandra. Not in itself suggestive of an assault but suggestive of a potential issue involving a Mental Health service user and it is for this reason that I do find that there should have been an attempt to see or speak to [redacted] to see how **he** was, after there had been a suggestion that he needed to leave his him immediately
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 **2nd February 2017** 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 family and legal representatives of the family of Sandra Brotherton.** 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	**08.12.2016** **Joanne Kearsley Acting Senior Coroner**