## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**Pennine Care NHS Foundation Trust**<br>**Churchgate Surgery**<br>**Tameside and Glossop CCG** |
| 1 | **CORONER**<br><br>I am Joanne Kearsley Area Coroner for Manchester South |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 29th November 2016 I concluded the Inquest into the death of Thomas Josef Green date of birth 1st November 1994 who died on the 10th June 2016 at his home address in Denton, Tameside Manchester.<br><br>I recorded that the deceased had a complex background. He had been assaulted in 2011 and also involved in a road traffic collision. These together with other life events were felt to have led to a diagnosis of post traumatic stress disorder.<br><br>The medical cause of death was confirmed as 1a) Asphyxiation secondary to hanging<br><br>Conclusion – Deceased had taken his own life |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>The Inquest into the death of Thomas Green had heard evidence that in August 2011 at the age of 16 he was assaulted. Following this he had difficulties leaving the house and became more isolated. On the first occasion he ventured out he was involved in a road traffic collision whereby as a pedestrian he was hit by a motor vehicle which didn't stop, sustaining injuries to his head and legs.<br><br>The Court heard that following this the deceaseds behaviour and personality totally changed. He was a virtual recluse, over time he became violent towards family members, he became paranoid and had mood swings. In September 2014 he was referred to the Early Intervention Team as he had expressed both suicidal and homicidal thoughts. Throughout October 2014 his violent behaviour |

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| | escalated towards family members and on the 13th November 2014 he was sectioned under Section 2 Mental Health Act. He remained an inpatient under the care of [redacted] from the 13.11.14 until the 5.12.14. During his admission he was diagnosed with Post traumatic Stress Disorder.<br><br>Despite his inpatient status he was referred by [redacted] on the 20th November 2014 to General Adult Psychiatry due to his "mixed personality disorder with paranoid and antisocial traits." It was unclear what happened with this referral but it was noted, as stated that this referral was made whilst Mr Green was an inpatient.<br><br>Whilst an inpatient Mr Green was also diagnosed as having a pineal tumour.<br><br>On his discharge from hospital Mr Green was placed under the Home treatment team. He remained under the Home Treatment team until 1st April 2015 at which stage he was discharged back to his GP.<br><br>On his discharge from hospital there was no follow-up by a Consultant Psychiatrist nor was there any referral for treatment for his diagnosis of Post traumatic stress disorder.<br><br>In July 2015 his GP made a referral to Tameside and Glossop Healthy Minds for one to one CBT. He had his first assessment on the 26th October 2015 at which stage he had a PHQ 9 score of 25 and a GAD score of 17. Due to difficulties attending and sporadic contact Mr Green was discharged from the Service.<br><br>A further referral was made by his GP in May 2016 and the deceased was on a waiting list at the time he died. |
| 5 | **CORONER'S CONCERNS**<br><br>The concerns noted by the Court during the course of the Inquest are as follows:<br><br>Pennine Care NHS Trust, Churchgate Surgery and Tameside and Glossop CCG<br><br>1. It was unclear why a referral was made to Adult General Psychiatry whilst Mr Green remained an inpatient, there was no evidence that this referral was ever considered or actioned.<br>2. Hence when Mr Green was discharged from hospital there was no psychiatric follow-up and no treatment plan in place to address the diagnosis of complex PTSD.<br>3. When a referral was made this was made to Healthy Minds. The Court heard evidence how this was not a case which was suitable for Healthy Minds as it was complex and involved potentially complex PTSD.<br>4. The Court heard evidence that the referral document completed by the GP was not particularly detailed and therefore the complexity of the case was not apparent and the case was accepted.<br>5. The Court heard evidence that there is a commissioning gap for the |

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| | provision of services for Complex PTSD and complex presentations such as that of Mr Green. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 14th April 2017 I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely, **the family of Thomas Green.**<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **16.02.2017** **Joanne Kearsley Area Coroner** |