REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Chief Executive of Pennine Care NHS Foundation Trust, Grosvenor Medical Centre Stalybridge,
1	CORONER I am Alison Mutch, Senior 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 13TH February 2017 I commenced an investigation into the death of David Ian Hamilton .The investigation concluded on the 1st June 2017 and the conclusion was one of suicide. The medical cause of death was 1aAspiration pneumonia and gastrointestinal haemorrhage;1bDrug toxicity (combined mirtazapine and paracetamol toxicity);II Ischaemic heart disease
4	CIRCUMSTANCES OF THE DEATH: David Ian Hamilton developed difficulties with his sleeping in October 2016. He sought help with his insomnia via A+E and via his GP. He self-referred to healthy minds for assistance. He was prescribed mirtazapine to assist. He attended group therapy sessions run by healthy minds. He became increasingly anxious and reported thoughts of self-harm both to his GP and at healthy minds group sessions. On the 7th February 2017, he was found dead at his home address. 10 Willow Wood Close, Ashton-under-Lyne.
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. Healthy Minds had no documentation or system of recording the selection process for therapy including the options given and rationale for the choice of therapy; 2. There was a lack of clarity of triggers for referrals other than group therapy; 3. The system of sharing information between health professionals(the GP and Healthy Minds) to identify if the correct services were being accessed or if a referral to a psychiatrist was required was limited and meant that those involved did not have a full picture of his mental health; 4. Referrals were not made to sleep clinic services to assist with insomnia 5. There was no evidence of a clear formal escalation process where concerns were held by a health professional
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 31st July 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 Alexandra Casson, the daughter of the deceased, who may find it useful or of interest. 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, 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	Alison Mutch HM Senior Coroner 5th June 2017