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:** The Senior Partner, The Surgery, Heaton Medical Centre, 2 Lucy Street, Bolton BL1 5PU
1	**CORONER** I am Alan Peter Walsh, HM Area 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 12th April 2017 I commenced an Investigation into the death of Frances Elizabeth Greenhalgh, 52 years, born 26th February 1965. The Investigation concluded at the end of the Inquest on the 7th September 2017. The medical cause of death was:- Ia Combined Toxic Effects of Mirtazapine and Dihydrocodiene. The conclusion of the Inquest was Suicide.
4	**CIRCUMSTANCES OF THE DEATH** 1. Frances Elizabeth Greenhalgh (hereinafter to referred as "the deceased") died at 10th April 2017. 2. On the 22nd March 2017 the deceased had been admitted to the Royal Bolton Hospital after she had taken an overdose of medication and she was referred to the Rapid Assessment Interface Discharge (hereinafter referred to as "RAID") Team. The RAID Team completes comprehensive mental health assessments and interventions within the Royal Bolton Hospital whether at the Emergency Department or on the Medical Wards. The RAID Team is part of the Greater Manchester Mental Health NHS Foundation Trust. 3. On the 22nd March 2017 the deceased had a full assessment by the RAID Team and the assessment concluded that there was no evidence of acute

mental illness but it was felt that the deceased had a common mental disorder (depression) and the most appropriate treatment for this was within the Primary Care setting. Following a Multi-Disciplinary Team Meeting the following plan of care was agreed:-

i. GP to monitor mood via Surgery fortnightly.
ii. GP to only prescribe 7 days medication at any one time to reduce the risk of overdose.
iii. The deceased to self-refer to Bolton Integrated Drug and Alcohol Service re alcohol use.
iv. The deceased was given the contact number for The Sanctuary Crisis Helpline and the deceased was also told that she could present to the Emergency Department if in crisis.
v. RAID to inform Primary Care Psychological Therapy Service a presentation and enquire whether a referral to the service can be expedited.
vi. Decision made to discharge the deceased from the RAID Team

The deceased agreed with the above plan and the RAID Team took immediate action to implement the plan.

At 16:40 hours on the 22nd March 2017 the RAID Team sent a fax message to the deceased's General Practitioner namely The Surgery, Heaton Medical Centre, 2 Lucy Street, Bolton (hereinafter referred to as "The Surgery") and also telephoned The Surgery to confirm that the fax message had been received. The Surgery confirmed that the fax message had been received and The Surgery was aware of the agreed plan.

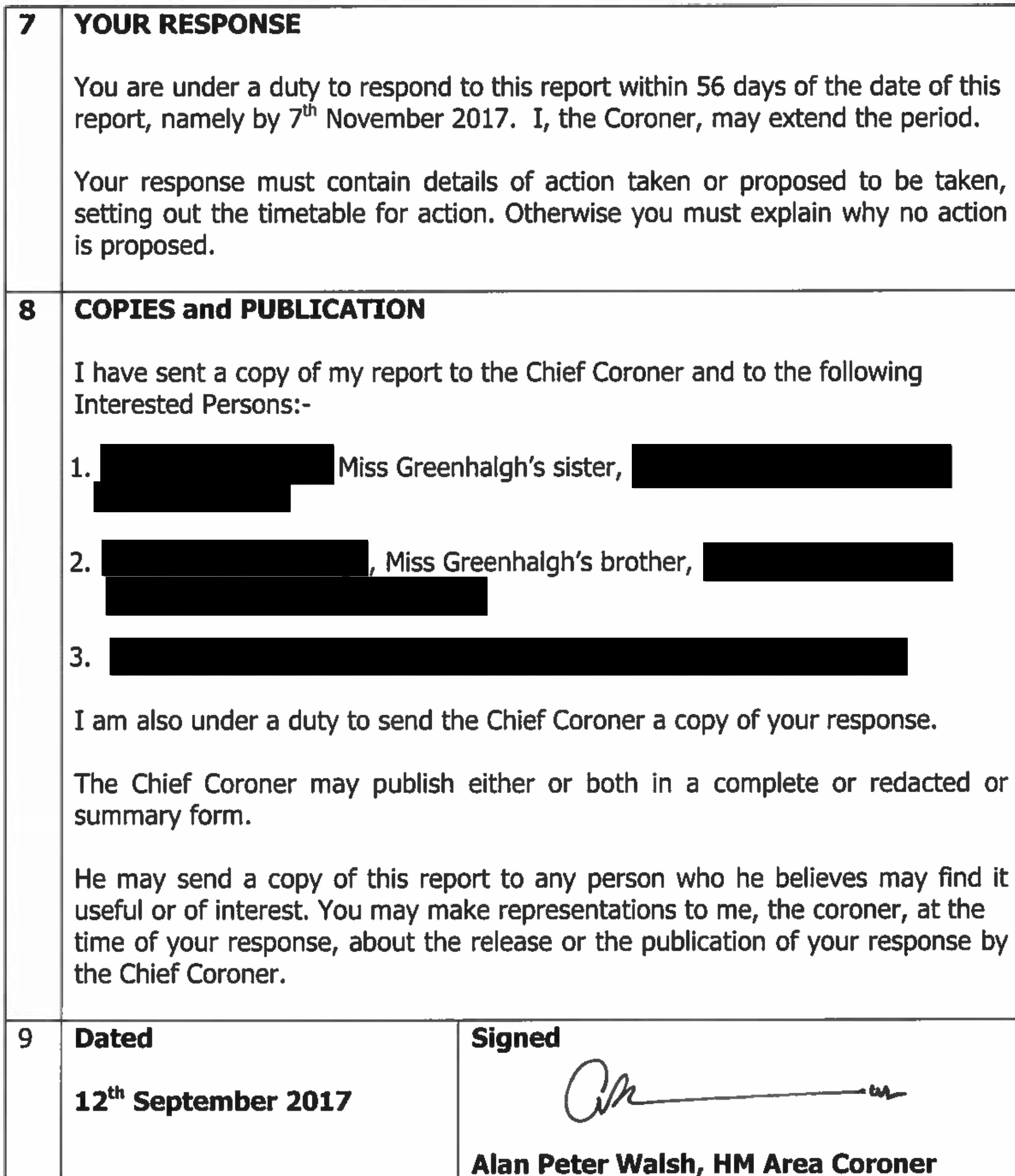
4. At the Inquest ██████████, who was a Locum General Practitioner at The Surgery, gave evidence as the General Practitioner on behalf of The Surgery and she confirmed that the letter from the RAID Team had only been put on The Surgery system on the 5th April 2017. She believed that the letter had only been received on that date but, obviously, she was unaware of the fax message and the evidence given by the RAID Team at the Inquest.

   Accordingly, ██████ was not aware of the plan for the GP to monitor mood fortnightly and the GP to prescribe 7 days medication at any one time. However, fortuitously ██████ had already implemented the issue of 7 day prescriptions prior to the 22nd March 2017 and ██████ had already made an appointment to see the deceased on the 4th April 2017, which was within the fortnight following her discharge from the Hospital.

   On the 4th April 2017 ██████ carried out an assessment sufficient to monitor the mood of the deceased. The action taken by ██████ was by her own action rather than in response to the letter from the RAID Team and she was unaware of the letter from the RAID Team when she conducted the assessment on the 4th April 2017.

5. On the 10th April 2017 the deceased was found in a collapsed and unresponsive condition at her home address at ████████████████████

	[redacted] having taken a substantial overdose of Mirtazapine and Dihydrocodiene and she was diagnosed as having died on that date.
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 Inquest evidence was heard that:- i. On the 22nd March 2017 the Surgery received a letter by fax message from the RAID Team in relation to a plan of treatment for the deceased which included actions to be taken by the General Practitioner. On the 4th April 2017, 13 days following the notification, the General Practitioner had not put the RAID Team notification with the deceased's medical records and there was no record of the notification on the computer systems at The Surgery. ii. [redacted] who no longer works at The Surgery, was not aware of any systems at The Surgery in relation to the receipt of notifications from Healthcare Professionals or the systems in relation to the recording of notifications and information on a patient's record so that the information is available to a General Practitioner on the next appointment with the patient. On the 4th April 2017 [redacted] was unaware of the notification from the RAID Team and there was no evidence that the deceased had received any communication from the General Practitioner after the 22nd March 2017 in relation to the plan agreed with the RAID Team on that date. 2. I request the Senior Partner of The Surgery to conduct a review of the documented protocols and systems relating to the processing and recording of notifications received from Healthcare Professionals, particularly where the notification is received from a Healthcare Professional outside The Surgery. The review should consider the training of Healthcare Professionals, including Doctors, and check systems to ensure that any notifications are recorded on the patient notes and on any computerised system available to Healthcare Professionals within The Surgery without delay so that the notification and any plan of treatment are available to a Doctor or Healthcare Professional at the next appointment with the patient. Furthermore the notification should trigger contact with the patient, if appropriate, and in any event, if the the agreed plan requires contact, to enable the patient to receive the benefit of treatment and care in accordance with the plan without delay.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe that 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 7th November 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:- 1. Miss Greenhalgh's sister, 2. , Miss Greenhalgh's brother, 3. 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** **12th September 2017** **Signed** **Alan Peter Walsh, HM Area Coroner**