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, the Chief Executive of CGL (Change, Grow, Live), the Practice Manager of Heaton Norris Health Centre.
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 15th November 2016 I commenced an investigation into the death of Lindsey Theresa Hassall .The investigation concluded on the 8th November2017 and the conclusion was one of Narrative: Died as a result of suspension from a ligature whilst under the influence of a cocktail of alcohol and drugs. The medical cause of death was 1a hanging
4	Lindsey Theresa Hassall had a subarachnoid haemorrhage in 2012. She had a history of substance abuse, primarily alcohol. She sought help from drug and alcohol support services and from mental health services and her GP in the 12 months preceding her death. On 16th October 2016, Lindsey Hassall was taken to the 136 Suite by Greater Manchester Police officers and seen on 17th October 2016. She had been seen whilst on a bridge. Her behaviour following her arrest and at the 136 Suite was volatile and she attempted to harm herself. This behaviour is not within the 136 documentation. She was not detained under the Mental Health Act and was discharged back to her GP. There was no referral to Healthy Minds or the Crisis Team. She saw a Lifeline worker subsequently on 31st October and 3rd November. No suicidal ideation was seen. It was not known she had been seen at the 136 Suite. On 1st November 2016 she went to Stepping Hill Hospital due to concerns about 'Spice' ingestion. She was discharged without a referral to RAID. No suicidal ideation was expressed. It was not known that she had been seen in the 136 Suite on 16th

	October 2016. Her GP saw her on 7th November. It was known that she had been to the 136 Suite in 2016 and that there had been previous suicidal thoughts. A referral was not made to the Crisis Team/Community Mental Health Team. An assumption was made that this had been done by the 136 Suite. It was clear from the 136 documentation that this was not the case. On 10th November 2016 Lindsey Hassall spoke to her Lifeline worker via telephone. An appointment was made for 23rd November 2016. She gave a positive impression. It appeared that she had been living rough in Heaton Norris Park for some of the time since 1st November 2016. On 11th November 2016 her body was found at Heaton Norris Park, seated under a tree, attached by a ligature that was around her neck. Toxicology taken after her death revealed that she had consumed alcohol 118mg% (blood), amphetamine, propranolol, promazine and sertraline prior to her death. Sertraline and promazine were at significant and potentially fatal levels.
5	<u>CORONER'S CONCERNS</u> 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. – • There is no provision for a record to be kept of the information, which Police Officers provide verbally to the RAID practitioners in the s.136 suite. The inquest heard that there was a record of the initial circumstances but no further record was kept. (Pennine Care) • Lifeline now known as CGL had dealt with the deceased in the period leading up to her death. The notes relating to that engagement were not input into the electronic system at the time. The inquest was told that the electronic system was updated from the notes after her death. Contemporaneous notes were then destroyed by the worker on the advice of her manager. (Lifeline/CGL) • The documentation held by Pennine Care was not easily accessible to all of the staff working for Pennine Care which meant that the full history of engagement was not known to workers dealing with her. • The form completed by the 136 suite team was sent to the GP with the box refer to GP ticked. After receipt by the GP practice there was an assumption that any necessary referral had already been made and no referral was discussed or made.
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 25th January 2018. 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 1) [redacted] father of the deceased 2) Greater Manchester Police 3) Stepping Hill Hospital, 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 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	Alison Mutch HM Senior Coroner 30/11/2017