REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. The Rt Honourable J Doyle-Price, Minister for Suicide Prevention, Department for Health and Social Care, 39 Victoria Street, London SW1H 0EU 2. [redacted] Chair NHS Tameside and Glossop Clinical Commissioning Group (CCG), Dukinfield Town Hall, King Street, Dukinfield SK16 4LA
1	**CORONER** Andrew Bridgman Assistant 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** Inquest touching the death of Heather Louise Carey. Opened 8th January 2018 Concluded 1st November 2018. Medical Cause of Death 1a Hanging Conclusion Suicide. Heather Carey took her own life when she had been in the care of NHS Mental Health Services for 6½ months; she had recently been placed on a waiting list of some 24 weeks for Cognitive Analytical Therapy. Although Heather Carey was known to be depressed, compounded by the lack of medication prescribed to lessen that depression, and at high risk of suicide from the time she had been discharged from hospital (following a serious overdose 6 weeks prior to her death) there was a failure to take adequate and appropriate action to avert or reduce that risk and, just 2 days before her death, inappropriate steps were taken which may have increased that risk.
4	**CIRCUMSTANCES OF THE DEATH** On 04.07.17 Heather Carey was admitted as a voluntary patient to the Mental Health Unit, Tameside General Hospital, seeking treatment for her enduring mental illness diagnosed as bi-polar disorder. Heather was detained under section 2 of the Mental Health Act on 13.07.17. On 24.08.17 Heather Carey was discharged. Her discharge medication was quetiapine, intended to lessen the depth of her depressive mood swings. Heather was expecting a referral to have been made that day for a psychotherapy assessment. On discharge Heather Carey's Out Patient Clinic Appointment was to be within 2-3 weeks (14.09.2017) but she was given an appointment on 04.10.17. Following this appointment Heather was referred for psychotherapy screening/assessment. That is the usual practice.

	On 02.11.17 Heather was admitted to Tameside General Hospital having taken an overdose of paracetamol. Quetiapine was stopped pending liver and renal function tests. Heather was discharged from Tameside General Hospital on 10.11.17. From discharge Heather Carey was a Red Zone high priority patient. Heather attended for her psychotherapy assessment on 22.11.17. The psychotherapist was not aware of the recent overdose. Heather was told that she was ready to consider Cognitive Analytical Therapy but that there was a 24-week waiting list. The psychotherapist sensed a disappointment. The evidence showed that for Heather it seemed like all hope had gone. Thereafter Heather's disengagement from the mental health team worsened. On the morning of 20.12.17 Heather Carey hanged herself at her home.
5	**CORONER'S CONCERNS** The inquest identified a number of issues which likely contributed to Heather's decision to end her life. One of those issues related to the long wait following discharge before psychotherapy would begin. At the time of Heather's admission to TGH there was no psychotherapy available to her as an in-patient because there were insufficient funds available to provide the same. I was told that had been addressed by further funding being made available. At the time of Heather's assessment on 22.11 staffing levels were reduced, through illness and a vacancy, and there was only one psychotherapist available. That was the reason given for the 24 weeks wait. At the inquest I heard evidence that the target waiting list was 18 weeks. Further, that by the time of the inquest that target time was being met. A target waiting time of 18 weeks, I was told, was comparable to 'cancer waiting times'. However, it transpires that those are the maximum waiting times for non-urgent consultant led treatment for any treatment from the point of referral. Heather was already in receipt of consultant led care. Her need was urgent. Thus such a comparator on waiting times to justify an 18 weeks wait for psychotherapy is not an appropriate measure. By letter dated 3rd January 2019 Pennine Care responded to my concerns about the long waiting list as follows, *"The CCG are currently in dialogue with Pennine Care in relation to waiting times for Secondary Care psychological therapies to ensure that **existing (emphasis added)** resources are effectively utilised and capacity and demand is reviewed to inform commissioning requirements."* The **MATTERS OF CONCERN** are as follows. – It was clear from the evidence heard, not only from Heather's mother and partner but from those involved in her care, that Heather had placed great faith in psychotherapy as the means by which she would bring mental stability back to her life, a release from the increasingly extreme mood swings of her bi-polar disorder. It is not difficult to imagine the despair and distress felt by Heather to be told that it would be almost 6 months before she could even begin the help/treatment she was seeking on voluntary admission some 4 months previously. . A target waiting list of 18 weeks is far too long but I was told that this was a funding issue. Unless adequate and sufficient measures are taken to significantly reduce waiting times for acute mental ill-health, comparable to physical life threatening illnesses, NOT simply a redistribution of existing resources, more patients with mental health issues will end their lives while on a waiting list for treatment.
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** 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. [redacted] Heather's mother 2. [redacted], Heather's partner 3. [redacted] Dep Managing Director Mental Health and Specialist Services, Pennine Care NHS Foundation Trust 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	**Andrew Bridgman** **HM Assistant Coroner** **12.02.2019**