REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Ms Claire Molloy, Chief Executive, Pennine Care NHS Foundation Trust, Trust Headquarters, 225 Old Street, Ashton-under-Lyne, OL6 7SR

CORONER

I am Chris Morris, Area Coroner for Manchester South.

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 6th March 2019, Alison Mutch OBE, Senior Coroner for Manchester South opened an inquest into the death of Ian Charles Bromley, who was found dead on 18th February 2019, aged 52 years. The investigation concluded at the end of the inquest which I heard on 19th August 2019.

At the end of the inquest, I determined that Mr Bromley died as a consequence of hanging. I recorded a conclusion of Suicide.

CIRCUMSTANCES OF THE DEATH

Mr Bromley first presented to mental health services in January 2019, experiencing low mood and suicidal thoughts connected with a range of personal difficulties. Following an initial assessment, Mr Bromley was offered an informal admission to hospital, but declined this. Instead, he accepted a referral to the Home Treatment Team as an alternative to inpatient treatment. This continued in the guise of one-to-one sessions with a mental health practitioner, alongside antidepressant medication prescribed by Mr Bromley's General Practitioner.

Mr Bromley was found dead on 18th February 2019 at his gym, having suspended himself by the neck with a ligature.

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. Despite the fact the Home Treatment Team purports to offer a genuine alternative to hospital treatment, it is a matter of concern that the Team does not currently have access to a dedicated Consultant Psychiatrist specifically allocated to the service;

2. Whilst the action plan which accompanied the Trust's internal investigation made reference to plans to recruit to such a post, the manager from the service who gave evidence appeared unaware of any substantive recruitment process currently in train, let alone the timescales within which it might reasonably be anticipated the post will be filled;

3. Although interim measures are in place whereby practitioners in the Home Treatment Team can access a psychiatrist on a rota system, the court heard evidence that the operation and effectiveness of these measures is patchy, with much depending on the individual approach of the particular psychiatrist in dealing with queries from this team alongside their existing workload.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 14th November 2019. 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

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to [redacted] on behalf of the family.

I have sent a copy of my report to Stockport Clinical Commissioning Group and the Care Quality Commission, 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.

Dated: 19th September 2019

Signature:

Chris Morris HM Area Coroner, Manchester South.