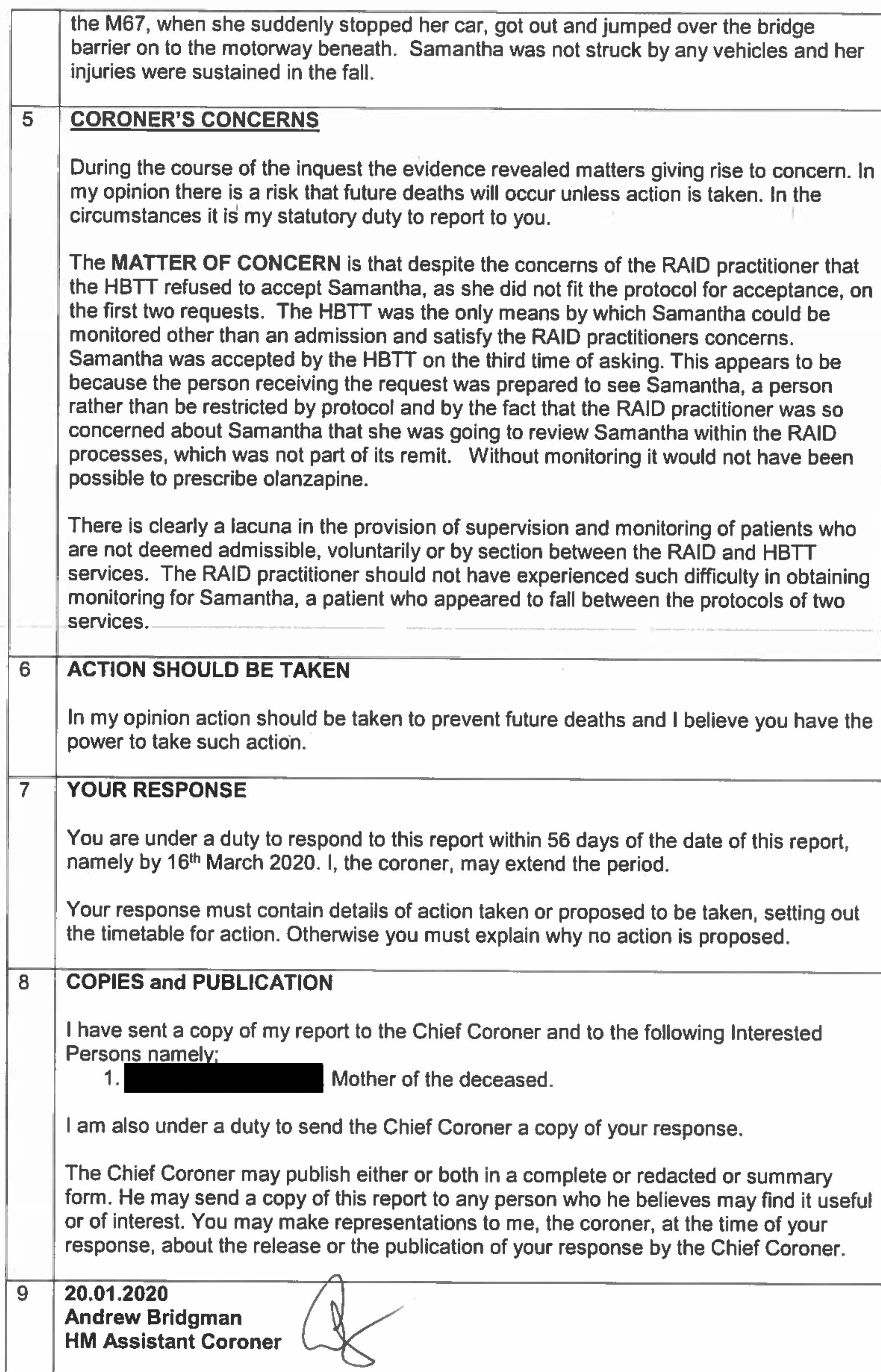
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: 1. Ms Claire Molloy, Chief Executive, Pennine Care NHS Foundation Trust, 225 Old Street, Ashton-under-Lyne, Lancashire OL6 7SR
1	**CORONER** I am 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** On 24.05.18 an investigation was commenced into the death of Samantha Savage-Greene. The investigations concluded on 03.12.18 at an inquest hearing; <u>Record of Inquest</u> <u>Section 2</u> 1a) Multiple injuries. <u>Section 3</u> On the morning of the 23.05.2018, Samantha Leigh Savage-Greene jumped from a bridge over the M67 motorway, East Hyde. <u>Section 4</u> Suicide
4	**CIRCUMSTANCES OF THE DEATH** About 4 years prior, Samantha suffered an episode of severe anxiety and tried to take her own life by cutting her wrists. She underwent a recovery over 12 months with CMHT. Samantha was then stable. On 18.05.2018 Samantha showed signs of a recurrence of anxiety. On 21.05.2018 Samantha went to her GP and was prescribed zopiclone. On 22.05.2018 Samantha attended A&E at Tameside General Hospital. She was seen by a RAID (Rapid Assessment Intervention & Discharge) team. Samantha was assessed as not needing admission. Samantha was prescribed olanzapine and was to be reviewed by the Home Based Treatment Team. The olanzapine prescription was to be issued by the GP. The RAID practitioner requested the HBTT (Home Based Treatment Team) to accept Samantha to; a) monitor her taking her medication; b) monitor the effects of the medication; c) monitor for deterioration. The HBTT declined to accept Samantha on the first and second times of asking. On a third time of asking Samantha was accepted. Samantha was discharged home from A&E. A HBTT home visit was scheduled for 24.05.2018. On 23.05.2018, at about 10.35 hrs, Samantha was driving her car over a bridge crossing



	the M67, when she suddenly stopped her car, got out and jumped over the bridge barrier on to the motorway beneath. Samantha was not struck by any vehicles and her injuries were sustained in the fall.
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 **MATTER OF CONCERN** is that despite the concerns of the RAID practitioner that the HBTT refused to accept Samantha, as she did not fit the protocol for acceptance, on the first two requests. The HBTT was the only means by which Samantha could be monitored other than an admission and satisfy the RAID practitioners concerns. Samantha was accepted by the HBTT on the third time of asking. This appears to be because the person receiving the request was prepared to see Samantha, a person rather than be restricted by protocol and by the fact that the RAID practitioner was so concerned about Samantha that she was going to review Samantha within the RAID processes, which was not part of its remit. Without monitoring it would not have been possible to prescribe olanzapine. There is clearly a lacuna in the provision of supervision and monitoring of patients who are not deemed admissible, voluntarily or by section between the RAID and HBTT services. The RAID practitioner should not have experienced such difficulty in obtaining monitoring for Samantha, a patient who appeared to fall between the protocols of two services.
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 16th March 2020. 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] Mother of the deceased. 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	**20.01.2020** **Andrew Bridgman** **HM Assistant Coroner**