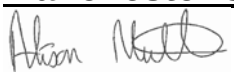
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Department of Health and Greater Manchester Health and Social Care Partnership
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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 25th November 2019 I commenced an investigation into the death of Carole Mitchell. The investigation concluded on the 3rd February 2021 and the conclusion was one of suicide. The medical cause of death was 1a) Diltiazem toxicity on background of hypertensive heart disease
4	CIRCUMSTANCES OF THE DEATH Carole Mitchell had a long history of involvement with mental health services, including being sectioned under the Mental Health Act and periods of voluntary admission at mental health units. Between 2017 and 2019, she was an inpatient on six occasions. She had three reported attempts to take her own life between 2017 and 2019. Throughout her time with Mental Health Services, she was reluctant to have information shared with her family. Her family were concerned about her deterioration. In 2019 however attempts by them to share information were not actively pursued by Mental Health Services and as a result information gathering that would have assisted in assessing her was limited. She was transferred from the Home-Based Treatment Team (HBTT) to the Community Mental Health Team (CMHT) on

	18th April 2019. There was a clear conflict in the understanding between the two teams regarding her care plan at handover, which was not recognised by either team. Following transfer to the care of the CMHT, she was seen less often. This was not fully detailed, or risk assessed. On 29th April 2019, it was decided Carole Mitchell would benefit from psychological assessment and she was added to the Secondary Care Psychology waiting list. The first appointment was 21st November 2019. The delay was due to a lack of appointments for that service. It was identified she would benefit from a support worker to work alongside the care co-ordinator. The first support worker's relationship was unsuccessful, and a decision was taken she should be replaced. There was a three month wait for a replacement support worker. There was no formal escalation to seek to prioritise Carole Mitchell, although it was clear the support service would be beneficial to helping her with her mental health. On 8th October 2019, her husband told mental health services that she had attempted to take an overdose on 6th October 2019. Following that disclosure, her case was not red zoned by her care co-ordinator and there was no face to face assessment to identify if any additional strategies would assist in supporting her or reducing risk. On 22nd November 2019, her husband left home at about 6:45am. He returned home to [redacted], Sale at about 6:15pm. He found Carole Mitchell unresponsive on the floor in the main bedroom. Police enquiries found no suspicious circumstances or evidence of third-party involvement in her death. There was no note or message found. Her medication was found by her bedside. Post-mortem examination, including toxicology, found that she had died from a fatal amount of her prescribed medication.
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. – 1. The inquest heard that psychology assessment and therapies can be very beneficial to those with mental health issues in secondary services as well as primary services. The evidence given was that the delay that Mrs Mitchell experienced in accessing that service was reflective of both the regional and national backlog for appointments. The inquest was told that the position had worsened since 2019 and for example someone in Mrs Mitchell's position today would be more likely to wait 9 months than the 7 months in 2019. 2. Mrs Mitchell on two occasions could not be accommodated locally when an inpatient stay was required. The evidence heard at the inquest was that this was due to limited national mental health bed capacity against the demand within mental health services. The inquest heard evidence that suggested that this impacted on how she could be supported by her family and overall care. 3. It was accepted at the inquest that information gathering from family could be beneficial. However, there was a reluctance by health professionals to fully utilise information gathering due to concerns about breaching patient confidentiality. This appeared to stem from a misunderstanding between the concept of information sharing and information gathering and how they inter related with the principle of patient confidentiality.
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 8th April 2021. 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 [redacted], the husband of Carole Mitchell and Greater Manchester Mental Health, 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 for the Coroner Area of Greater Manchester South**  **11/02/2021**