REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Southern Health NHS Foundation Trust of** Tatchbury Mount, Calmore, Southampton, SO40 2RZ 2. **General Medical Council** of Regents Place, 350 Euston Road, London NW1 **3JN and by email to** standards@gmc-uk.org 3. **The National Institute for Health and Care Excellence** of 2nd Floor 2 Redman Place, London E20 1 JQ
1	**CORONER** I am SAMANTHA MARSH, an assistant coroner, for the coroner area of HAMPSHIRE, PORTSMOUTH AND SOUTHAMPTON
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 16th August 2019 I commenced an investigation into the death of Sarah Jane Buckingham Smith, aged 54. The investigation concluded at the end of the inquest on 19th January 2021. The conclusion of the inquest was Suicide.
4	**CIRCUMSTANCES OF THE DEATH** On the Twelfth of August 2019, at her home address of [redacted] in Liphook, Sarah Jane Buckingham SMITH took her own life by hanging herself in the loft. She had been suffering from clinically recognised depression and had, the previous month, voluntarily admitted herself to Elmleigh Hospital in a bid to aid her recovery. At the time of her death she had high levels of anti-depressant prescription medication in her system. Her intention when taking the medication in this quantity is unclear.
5	**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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – At Sarah's Inquest I heard that she had suffered Post Natal Depression (PND) following the birth of both of her children, in 1997 and 2002 respectively. Her last episode of depression in 2002 was very severe, with Sarah agreeing to a voluntary admission as an inpatient at a mental health hospital (although it was acknowledged that she would have been Sectioned under the provisions of the Mental Health Act at that time had she not

	agreed to a voluntary admission). During both of these previous episodes of mental health illness it was felt that there was a possible hormonal contributory factor within Sarah's presentation, and it was noted that aside from these instances of depression Sarah had been a resilient, robust and highly functioning lady. Sarah had been started on Hormone Replacement Therapy (HRT) by her GP in November 2017 as she was peri-menopausal. She began to experience and suffer from symptoms of depression once again in March 2019, and was clinically diagnosed with a depressive illness and anxiety. It was only during a voluntary hospital admission between 28th – 30th July 2019 that Sarah had a blood test taken, which included a hormone profile. This was some four months into her illness and was only taken as 'routine'. It transpired from the evidence at Sarah's Inquest that hormone treatment and/or hormonal triggers for depressive illness were not considered by the Mental Health Clinicians treating Sarah. I heard evidence that those treating Sarah relied on, and followed, NICE Guidelines but that NICE Guidance on Depression does not say anything about the routine monitoring of hormones, or that consideration be given to this potential contributory factor when treating menopausal or perimenopausal women. The significant impact of changing hormones was considered very early on in Sarah's treatment for PND, but was not considered at all during her last episode of depression; with no justification or explanation as to why the impact of changing hormones was considered significant after birth, but not significant during menopause. I believe that an early consideration of these issues when treating a menopausal patient, and understanding of the potential interplay between hormonal changes and depression, may assist in formulating an effective treatment plan for patients such as Sarah.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation 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 **19th May 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; Mrs Smith's Husband, [redacted] I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.

9	**22nd February 2021**