REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Rt.Hon. Matt Hancock MP, Secretary of State for Health and Social Care.
1	CORONER I am Chris Morris, Area Coroner for the coroner area of Greater Manchester (South).
2	CORONER'S LEGAL POWERS I make this report under Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	INVESTIGATION and INQUEST On 9th April 2020, I opened an inquest into the death of Joanna Leven who was found dead at her home on 26th March 2020, aged 34 years. A post mortem examination undertaken by Dr [redacted], consultant pathologist, determined that Ms. Leven died as a result of asphyxia. The coronial investigation into her death concluded with the inquest, which was heard before me on 26th – 27th April 2021, resulting in a conclusion that Ms. Leven had died as a consequence of suicide.

4	CIRCUMSTANCES OF THE DEATH Ms. Leven was found dead at her home on 26th March 2020 as a consequence of asphyxia which was self- induced with the intention of bringing about her death. Ms. Leven was under the care of community mental health services having previously been diagnosed with Emotionally Unstable Personality Disorder arising from traumatic experiences in childhood. As a result of her Personality Disorder, Ms. Leven had frequently self- harmed and/or attempted suicide, often telling others what she had done. A major protective factor in maintaining Ms. Leven's safety was her dog. In February 2020, Ms. Leven's dog became seriously unwell. This led to a profound deterioration in her mental health. After Ms. Leven's dog was euthanized in March 2020, she cut her groin and took a mixed overdose, resulting in her being taken to hospital. Whilst she received treatment there for her physical health, Ms Leven left hospital before the mental health liaison team could assess her. Despite the clear deterioration in Ms. Leven's health, the removal of the major protective factor in maintaining her safety and her e-mailing her care coordinator to inform him she intended to complete suicide after leaving hospital, no comprehensive mental health assessment took place. It is possible the absence of a comprehensive mental health assessment at this point in Ms. Leven's life might have contributed to her death.

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 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 court heard evidence that there is no national therapeutic pathway for treatment of Personality Disorders. Whilst the court heard steps are in place to introduce a local pathway for residents of Greater Manchester, it is understood eligibility for and availability of various therapies which may be beneficial to patients diagnosed with a Personality Disorder varies from place to place; 2) Evidence was heard in court to the effect that there are gaps in provision by statutory agencies of counselling and other mental health services specifically tailored for victims of trauma, violence and domestic abuse. In Stockport, specialist services of this nature fall to be provided by a registered charity with only short-term funding in place, a position which is understood to be replicated elsewhere in the country; 3)The court heard evidence that, where a patient attends a Hospital Emergency Department with both physical and mental health needs, it is usually the case that Hospital and Mental Health Liaison staff are working with different computer-based records systems. This creates an obvious risk of information being lost or incompletely conveyed as between different professional groups.
6	ACTION SHOULD BE TAKEN In my opinion, action should be taken to prevent future deaths and I believe that you and/or 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 25th June 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 following: · HHJ Thomas Teague QC, the Chief Coroner of England and Wales; · [redacted] on behalf of Ms Leven's family; · [redacted] of Stockport Metropolitan Borough Council; · [redacted] of Hempsons LLP, Solicitors to Pennine Care NHS Foundation Trust; · [redacted] of Weightmans LLP, Solicitors to North West Ambulance Service NHS Trust; · DCI [redacted] of Greater Manchester Police; · [redacted] of Stockport Without Abuse; and · [redacted], Independent Chair, Safeguarding Adult Review. I am 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	**30th April 2021** **Christopher Morris, HM Area Coroner, Manchester South.**