REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **Stockport Clinical Commissioning Group and NHS England**
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 23rd February 2021 I commenced an investigation into the death of Bituin Pimlott. The investigation concluded on the 13th August 2021 and the conclusion was one of suicide. The medical cause of death was 1a hanging.
4	CIRCUMSTANCES OF THE DEATH On 22nd February 2021 Bituin Pizzaro Pimlott was found suspended from a ligature at the garage at her home address [redacted] Park Lodge. There were no suspicious circumstances and no evidence of third-party involvement in her death.
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. – The inquest heard evidence that Mrs Pimlott had been struggling with her mental health in the weeks preceding her death and had contacted her GP on a number of occasions with anxiety and depression. She was prescribed medication but expressed concerns about the impact of the medication. Telephone consultations rather than face to face

	appointments continued to be used with her due to the pandemic. Pre Covid it was accepted she would have been seen face to face which would have allowed a more comprehensive assessment of her mental health and her reluctance to use medication. Her GP practice did not refer her to the crisis team, and it was unclear what guidance the practice had for their GPs about when they should refer directly to the crisis team.
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 1st November 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] (family of the deceased), 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	**6th September 2021**  **Alison Mutch** **HM Senior Coroner Greater Manchester South**