REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Rt. Hon. Sajid Javid, Secretary of State for Health and Social Care
1	CORONER I am Chris Morris, Area Coroner for 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST On 25th June 2021, Anna Morris, Assistant Coroner, opened an inquest into the death of Joy Burgess who died on 9th June 2021 aged 56 years. The investigation concluded at the end of the inquest which I heard on 4th February 2022. A post-mortem examination undertaken by [redacted] Consultant Pathologist, determined Ms Burgess died as the result of multiple injuries. By way of conclusion, I recorded that Ms Burgess died as a consequence of suicide.
4	CIRCUMSTANCES OF THE DEATH Joy Burgess died from multiple injuries sustained as a consequence of [redacted]. Ms Burgess had a long history of complex mental health difficulties and had been under the Community Mental Health Team. In addition to being prescribed medication, Ms Burgess was on a lengthy waiting-list to access psychological therapies. In May 2021, Ms Burgess's mental health deteriorated with her developing an increasing array of depressive symptoms, anxiety which was providing difficult to manage in the community, and thoughts of self-harm.

	She was admitted to hospital as a voluntary patient, but took her own discharge a number of days later. Ms Burgess disclosed to staff that this was because she found the ward environment was busy and extremely noisy. Ms Burgess described being disturbed by the screams of some of the patients, and considered being on the ward was making her feel worse. Upon leaving the ward, Ms Burgess was followed-up by her Care Co-Ordinator and the Home Treatment Team.
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 the mental health ward environment could be 'chaotic' (in the words of one Consultant Psychiatrist) and that resources and demands on inpatient beds were such that staff were not always able to care for patients in a suitable environment. It is a matter of concern that mental health patients are, on occasion, cared for in an environment which is very obviously not conducive to recovery. 2. The Court heard that patients continue to experience lengthy waits if referred for psychological therapies, both locally and nationally. In the Tameside area, the current average wait was thought to be around one year from referral.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you and 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 1st May 2022. 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 [redacted] on behalf of the family and Pennine Care NHS Foundation Trust.

	I have also sent a copy of my report to Tameside Metropolitan Borough Council, the Care Quality Commission, and Greater Manchester Health and Social Care Partnership, all of whom I consider may find the report 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	Dated: 4th February 2022 Signature: Chris Morris HM Area Coroner, Greater Manchester (South.)