REGULATION 28: REPORT TO PREVENT FUTURE DEATHS.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • Dr. [redacted] Medical Director GMMH NHS Trust Trust HQ, Bury New Road, Prestwich, Manchester M25 3BL Copied for interest to: • [redacted] • The CQC
1	**CORONER** I am: Senior Coroner Nigel Meadows Senior Coroner for Manchester City Area HM Coroner's Court and Office Exchange Floor The Royal Exchange Building Cross Street Manchester M2 7EF
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 the 12th February 2021 I commenced an investigation into the death of. The investigation concluded on the 18th February 2022. The Conclusion of the inquest was**: Narrative Conclusion:** The deceased suffered from chronic illicit drug abuse and mental disorders. She was sent to Prison the 13 October 2020 and transferred to a mental health unit on the 10 December 2020 and remained a patient detained under the Mental Health Act until the 13 January 2021 when she was discharged.

	She was found in a state of cardiac arrest on 30 January 2021 and died in Wythenshawe Hospital on the 31 January 2021. It was not possible to determine the cause of her cardiac arrest.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was reported to suffer from mental illness but there was a recognised lack of defined diagnostic certainty. However, she did been established history of illicit and prescribed drug misuse as well as past contact with mental health services over several years, homelessness, a chaotic lifestyle and being vulnerable. She had a significant forensic history and had served previous custodial sentences. Following the deceased's death the GMMH NHS trust carried out a serious incident investigation and identified several significant issues relating to her care and management. In July 2020 she was taken by the police to hospital as a place of safety and was expressing suicidal ideation but failed to engage with an assessment and self-discharged. In September 2020 she was admitted to hospital and treated for heroin overdose but once again self-discharged. She was convicted of an assault offence serious enough for her to be sent to Prison on the 13 October 2020. Whilst in prison she was diagnosed with presenting with psychotic symptoms and was prescribed several drugs including antipsychotics and antidepressant medication but with either none will poor compliance. On the 10 December 2020 she was transferred to a secure psychiatric intensive care mental health unit (PICU) and was diagnosed with Psychosis although she continued to make threats of physical abuse to staff. She remained detained under the Mental Health Act when her sentence on imprisonment finished on the 14 December 2020 and continued to be treated with antipsychotic medication. On 12 January 2021 she was reviewed for consideration of a supported discharge by the Home based Treatment Team (HBTT) it was concluded that she was not suitable for that form of supported community treatment and would benefit from a further period in hospital and would require a formal MHA and capacity assessment. The clinical records did not demonstrate how this conclusion was reached nor why this rationale was appropriate. There was an inadequate mental state examination. On 13 January 2021 she went AWOL from the ward but instead of asking her to return she was discharged from the hospital despite her having no fixed abode and inconsistently engaged with Community Mental Health Services over a long period of time. Nonetheless, she was still discharged to the HBTT even though this was inconsistent with the assessment that she was not ready for community treatment. They were were asked to do a standard 72 hour/4/7 day follow up. There was no clear clinical rationale for this decision or appropriate records made or apparent regard had to her chronological history or correlate established facts and relevant factors. The risk assessment was inadequate. There was a failure to rule out any physical causation for some of or all of her symptoms or clearly document why further detention under the MHA was impracticable or legally inappropriate. However, the dosage of her antipsychotic medication was being increased. Some of the clinical records make references to her "not taking responsibility for her own care" which is stigmatising and "no clear role for HBTT" but without clear clinical reasons.

	On he 18 and 19 January she saw a HBTT practitioner and consented to the administration of her Depot medication but appeared sedated. She failed to attend 4 subsequent appointments for review or administration of her Depot and indicated when contacted by phone that she would no longer accept her Depot. On the 30 January 2021 she was found at [redacted] Broadheath, Altrincham, Greater Manchester in a state of cardiac arrest. When the paramedics attended there were two men present in the room who would not identify themselves and it was believed that she had been moved from the sofa to the floor by one or both of the men. They said she no fixed address and was a drug user and have been taking heroin and an unknown quantity of pregabalin. Subsequently these men could not be identified by the police were associated with extensive records of offences of drug possession, assaults, public order and affray at the premises. It could not established with any certainty how long she had been in cardiac arrest or its precise cause although it was thought likely that it was drug-related. She was resuscitated and taken to Wythenshawe Hospital where she was then diagnosed with a hypoxic brain injury. Despite treatment her condition deteriorated, and she died on the 31 January 2021. Pathologically it was not possible to determine the calls cardiac arrest.
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 repeated instances of inadequate or incomplete necessary clink clinical record keeping. 2. The decision made to discharge to community HBTT care when they had indicated that the patient was not ready for supported community care and there had been no clear clinical rationale. 3. Discharging a patient with a long forensic history and inconsistent engagement with mental health services who still required administered Depot antipsychotic medication and was a vulnerable adult. 4. Inadequate and incomplete risk assessments and mental state examinations. 5. Discharging a patient who had no appropriate fixed abode and no established community family support arrangements. 6. A significant failure to consider a safeguarding referral and assessment for a vulnerable adult suffering from serious mental disorder.
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 the 21st June 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 Interested Persons. I have also sent it to organisations 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	**DATE: 19th April 2022** **Mr Nigel Meadows** HM Senior Coroner Manchester City Area **Signed:**