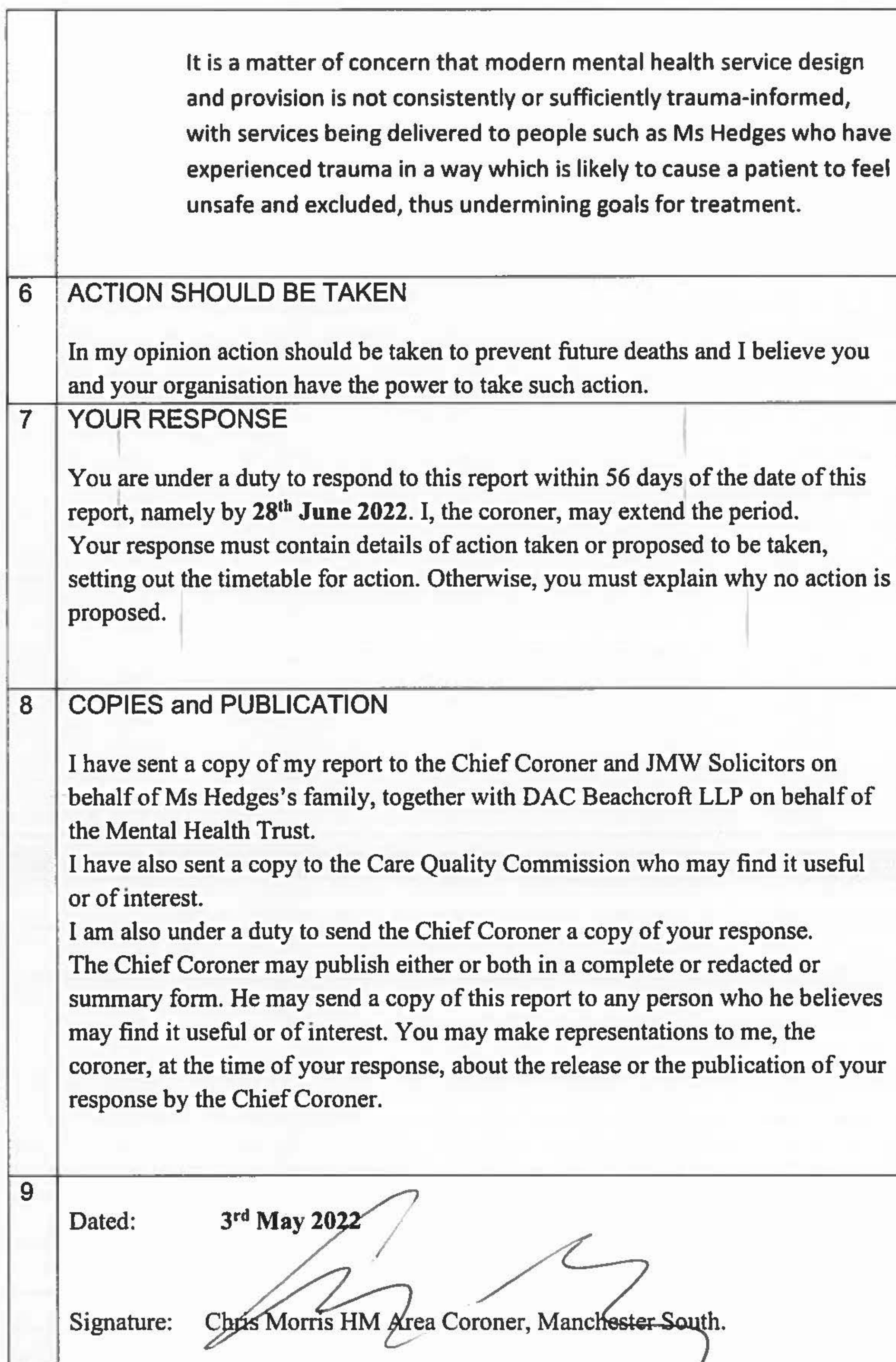
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) Chief Executive, Greater Manchester Mental Health NHS Foundation Trust 2) Rt. Hon. Sajid Javid MP, Secretary of State for Health and Social Care
1	CORONER I am Chris Morris, Area Coroner for 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 11th December 2020, Alison Mutch OBE, Senior Coroner, opened an inquest into the death of Kate Hedges who died on 27th November 2020 at Gatley Railway Station, Gatley aged 35 years. The investigation concluded with an inquest which I heard between 19th – 22nd April 2022. The inquest concluded with a Narrative Conclusion to the effect that Kate Hedges died as a consequence of injuries sustained when she whilst the balance of her mind was disturbed by severe mental illness
4	CIRCUMSTANCES OF THE DEATH Kate Hedges died on 27th November 2020 at Gatley Station as a consequence of injuries sustained when she was . Ms Hedges had deliberately Ms Hedges had a complex mental health history and had been diagnosed with Post Traumatic Stress Disorder. Following an acute deterioration in her mental

	health, Ms Hedges was admitted to hospital under the Mental Health Act where she underwent monitoring and treatment with antipsychotic medication. On 27th October 2020, Ms Hedges was discharged from hospital under the care of the Home Based Treatment Team. Ms Hedges's family were neither informed of the decision to discharge her nor consulted in this regard. Ms Hedges remained under the care of the Home Based Treatment Team following a house move on 5th November 2020. After this point in time family members considered Ms Hedges to seem low in mood and withdrawn. Both in Hospital and when followed up in the community Ms Hedges was consistently considered to present a low risk of deliberate self-harm, citing her son as a major protective factor.
5	<u>CORONER'S CONCERNS</u> The MATTERS OF CONCERN are as follows. – **<u>To the Chief Executive, Greater Manchester Mental Health NHS Foundation Trust</u>** 1. The court heard evidence that the Trust's Psychological Therapy serviced used (and continues to use) a different computerised record-keeping system from that used by staff providing acute mental health services, which the latter staff group do not necessarily have access to. It is a matter of concern that this approach means staff undertaking risk assessments and formulating care plans may on occasion be doing so without access to all relevant information. This was certainly true in Ms Hedges's case. 2. It is also a matter of concern that, following disclosure by Ms Hedges at a multidisciplinary meeting of a serious allegation to the effect that she was touched inappropriately by another patient, the Trust's own safeguarding policy was not followed. **<u>To the Secretary of State for Health and Social Care</u>** 1. The court heard evidence to the effect that Ms Hedges often found the environment of a (mixed-sex) mental health ward distressing and difficult, both as a result of her illness and the ongoing effects of traumatic experiences endured at various stages of her life.



	It is a matter of concern that modern mental health service design and provision is not consistently or sufficiently trauma-informed, with services being delivered to people such as Ms Hedges who have experienced trauma in a way which is likely to cause a patient to feel unsafe and excluded, thus undermining goals for treatment.
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 **28th 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 JMW Solicitors on behalf of Ms Hedges's family, together with DAC Beachcroft LLP on behalf of the Mental Health Trust. I have also sent a copy to the Care Quality Commission 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	Dated: **3rd May 2022** Signature: Chris Morris HM Area Coroner, Manchester South.