REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Pennine Care NHS Foundation Trust** **2. Chief Executive, Oldham Borough Council**
1	**CORONER** I am Joanne Kearsley, area coroner, for the coroner area of 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 the 5th April 2013 I commenced an investigation into the death of Gareth Mark Slater date of birth 11.04.1982. The Investigation concluded at the end of the Inquest on the 29th January 2014. The conclusion of the Inquest was that Mr Slater had died as a result of 1a) Drowning 1b) Multiple Injuries II) Bipolar Affective Disorder. On the 31st March 2013 the deceased, who had a history of mental illness, was found in the River Medlock having apparently fallen from Bardsley Bridge. There was no evidence found of any intention to end his life. The conclusion was an open conclusion.
4	CIRCUMSTANCES OF THE DEATH Circumstances – the Inquest heard evidence that the deceased had at the age of 19 developed a severe and enduring mental illness and had been diagnosed with Bipolar Affective Disorder. As a result of this he had spent substantial periods of time in hospital including a five year admission from 2007 until 2011. In addition to his mental illness the deceased also used alcohol and illicit substances which could impact on his mental health. It was noted at the Inquest that self-harming behaviour and suicidal ideation was not a feature of Gareth's mental illness. In 2011 he had been released from hospital, low secure services, under the terms of a Community Treatment Order into supported accommodation. Within 5 weeks the deceased had been readmitted to hospital. It had been envisaged that he may need to be readmitted to hospital but that this would be for short periods of time. The deceased was readmitted into Oldham in-patient services. Following his admission there was a difference of opinion between his Clinical Team as to whether Gareth required admission back to low- or indeed medium-secure services or whether he could be released again on the Community Treatment Order. This impasse lasted until November 2012, some 16 months after his readmission. It was unclear from the evidence exactly when the decision was taken that Gareth would be discharged under the Community Treatment Order, however on the 5th October 2012 Gareth signed a tenancy for a flat with the help of his STAR worker and on the 22nd October 2012 Gareth's care was transferred to a different Consultant and he was moved to a different Ward. In addition on the 8th October 2012 his case was given to a new care co-ordinator. Following a Professionals meeting on the 23rd October a date of the 6th November 2012 was set by the Consultant Psychiatrist as the date of Gareth's

	discharge from hospital. Gareth was subsequently discharged and moved into his own accommodation. Following his discharge Gareth attended A&E on one occasion on the 15th February 2012 when he indicated that he had been using illicit substances, not complying with his medication and felt that he "couldn't cope". He was assessed and it was noted that there was no deterioration in his mental illness. He was not readmitted. On the 18th March he met with his Out Patient Consultant Psychiatrist who renewed the Community Treatment Order. In the weeks leading up to his death he had admitted to his family and his Psychiatrist that he was having some difficulties with people using his flat. On the 29th March he had been collected from his flat by his family and had stayed at his Grandmother's house. He left her house on the morning of the 30th March. It has not been established where he was until he was found 24 hours later on the 31st March. There were no witnesses to the incident.
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 discharge planning in relation to Mr Slater was overshadowed by the impasse in clinical opinion and the length of time it took to resolve this. No doubt because of the difficulties to resolve Gareth's situation there was a failure to actually carry out the important task of discharge planning. No care plan was in place for Gareth, merely a recognition of the conditions of his Community Treatment Order. 2. There was no Section 17 discharge planning meeting. 3. There was no further assessment since 2011 of Gareth's ability to live independently (as opposed to in supported accommodation which had failed). 4. There was no attempt to involve Gareth's family in the discharge of Gareth. 5. There was no use of extended periods of leave for Gareth to assess his ability to manage his tenancy. 6. On his discharge the flat was unfurnished, without carpets and he was not able to reside there. The condition of the flat at the time of Gareth's death remained sparsely furnished with a large water leak in the kitchen. 7. There was no planning as to requirements Gareth may need or could be considered to help structure his day i.e. activities, etc. 8. The discharge summary was not dictated and sent to his new outpatient Consultant until the 18th February over three months from his discharge from hospital. There were no follow up appointments in place for Gareth at the time of discharge. 9. The renewal of his Community Treatment Order was rushed, a piece of work which would normally take weeks to carry out was given to an Approved Mental Health Practitioner on the Friday afternoon before Gareth's appointment at 10am on the Monday morning, meaning that she had just over an hour to consider the suitability of the CTO being renewed. 10. The lack of a structured and considered Care Plan meant that the only person having any contact with Gareth in the Community was his Care Co-Ordinator who had only been involved with Gareth since the 8th October 2012 . There was no guidance to his Care Co-Ordinator as to how often Gareth should be seen.
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 30th March 2014. 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, the Coroners' Society website and to the following Interested Persons namely [redacted] mother of the deceased. 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	30 January 2014 Joanne Kearsley, Area Coroner