REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Executive, Pennine Care NHS Foundation Trust
1	**CORONER** I am Ms L J Hashmi, Area Coroner for the Coroner area of Manchester North.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 11th November 2016 I commenced an investigation into the death of **Astonn Mitchell-Male.** The investigation was concluded by way of jury inquest on the 25th July 2018.
4	**CIRCUMSTANCES OF DEATH** Mr Mitchell-Male was known to suffer from Schizophrenia/Psychosis and had been under the care of Psychiatric services for a number of years. He had a history of attempts at self harm, non-compliance with medication, substance misuse and a tendency to self-medicate. He had also come into contact with the criminal justice system. At the time of his death he was living within the community in supported accommodation and had a care co-ordinator. Between August and October 2016 his mental health showed signs of deterioration, resulting in periods of detention under the Mental Health Act (S.136, S.135 and S.2). On the 31st October 2016 police were contacted at around 21:14 by the on-call Support Worker with a concern for welfare (based on Mr Mitchell-Male's mental health issues) and a noise complaint (shouting and noise having been heard coming from Mr Mitchell-Male's first floor flat by another resident). In light of the mental health element and concern for welfare, the call was graded as requiring allocation within 40 minutes and attendance in the hour. The ambulance service was asked to attend. Both the police and ambulance were delayed. When police arrived at around 23:05, there was no sign of noise/disturbance. They were unable to gain entry to Mr Mitchell-Male's accommodation. They checked the perimeter of the property, knocked on the ground floor windows and 'buzzed' the door bells. There was no response. Police left a short time later and the ambulance was cancelled. On the 1st November 2016 Mr Mitchell-Male's mother discovered a voicemail that had been left by her son the night before at around 20:52. He was clearly in distress. She contacted police and arranged to meet up with a police officer at Mr Mitchell-Male's address. Upon entering the flat at around 09:20, Mr Mitchell-Male was found deceased with multiple stab/incise injuries which were the direct cause of his death. The jury found that Mr Mitchell-Male: '...died from multiple self-inflicted stab and incise wounds on or around the evening of 31.10.16 due to a deterioration of his mental state...' [*sic*] & that care provision by the mental health service, police and supported accommodation had been lacking, inadequate and/or insufficient.
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. There is no policy in existence within the Trust to address the process of patient medication monitoring/compliance and the triangulation of corroborative information, particularly within the community setting. 2. There was evidence to show that record keeping was poor and at some points non-existent. Records are a vital form of communication about the patient's condition and care provision. As such, poor compliance goes to the issue of patient safety.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 the 20th September 2018. 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:- - Mr Mitchell-Male's family - All other Interested Persons - Bury CCG - for information purposes only - CQC 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 from. 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: 26th July 2018 Signed: