REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Constable Ian Hopkins, Greater Manchester Police (GMP) 2. Chief Executive Pennine Care NHS Trust (PCT) 3. Chief Executive NWAS (NWAS) 4. Jon Rouse, Chief Officer for the Health and Social Care Partnership and Chair of the Health & Justice Board
1	**CORONER** I am Ms Joanne Kearsley, Senior 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 20th December 2018 I concluded the Inquest into the death of Mr Gregory Rewkowski (GR) who died on the 29th October 2017 at his home address. A jury reached the following conclusion in respect of Mr Rewkowski's death: "*On the balance of probabilities the deceased died as a result of hanging at his home address. It is more likely than not he intended to end his life. Having listened to the evidence the jury determined that Pennine Care NHS Trust should have informed the next of kin of the deceased's discharge from hospital and information about his social media posts. The Jury determined the breakdown in communications with Pennine Care NHS Trust, Greater Manchester Police and North West Ambulance Service resulted in the deceased not being contacted until 28th October 2017. The lack of knowledge of procedures and policies of all services led to a delay in acting in a timely and appropriate manner. It is the jury's findings these failings did not make any contribution to the death*".
4	**CIRCUMSTANCES OF DEATH** The circumstances leading up to GR's death are as follows: On the 17th September 2017 he was taken from his home address on a Section 136 by Greater Manchester police to hospital where he was detained under Section 2 of the Mental Health Act, having been found, by chance, by his friends, trying to tie a ligature. Of note, he was taken to hospital from his home on a Section 136. GR remained in hospital until the 26th October 2017 when he was discharged to his home address. It was acknowledged by PCT, that whilst he was a patient and had provided his consent for his ex-partner to be involved in aspects of his care, there was no attempt made to invite her to ward rounds or to discuss discharge planning. The plan was for him to be discharged on the 30th October, however GR requested his own discharge on the 26th October. At this time he was an informal patient and there were no grounds to detain him. On the morning of the 27th October 2017 another patient alerted the clinical unit lead (AM) to the fact GR had posted on social media his "last goodbyes". The evidence of the clinical lead AM was she had asked a nurse, TC, to raise a concern for welfare. TC had no recollection of this. No action was taken until another nurse LD came on duty. Aat 15.57 a concern for welfare call was placed to GMP. The concern for welfare related to the risk to the life of GR. The Court heard evidence from 4 registered mental health nurses from PCT and other witnesses including a Consultant Psychiatrist. All provided evidence to the Court of their understanding of the escalation of concerns for welfare in such circumstances. It was evident all understood the process to be in the event of a

concern for welfare in these circumstances, it was the police who were contacted to respond.

The call handler in GMP graded the call as requiring allocation within 20 mins and attendance within one hour.

The Court also heard how every PCT and GMP witness were of the opinion GR required a face to face assessment.

Having switched the call to a Radio Operator and Radio Assist, the Court heard how both these witnesses were of the opinion, from the information provided, that this was a "*medical matter*". The Court noted these opinions were not based on the availability of resources but on the understanding different agencies (Mental Health services and social services) were using the Police, particularly on a Friday afternoon as this was, to complete tasks which they had not finished. The witnesses understood this view had been acknowledged by the Senior Leadership Team in GMP who had through "*emails and snippets of information*", promoted the view that such matters should be "*pushed back*" to the reporting agency.

The duty Sgt was contacted and acknowledged he was advised this was medical matter. He agreed he did not dispute this opinion. At the time there was another incident requiring allocation and he advised the Court this would have taken all available resources.

At 16.15 GMP contacted nurse LD and advised her she needed to report the matter to NWAS as it was a medical matter. This was unexpected advice for nurse LD who questioned whether it was for her to do this. She was advised it was.

The GMP Radio Operator, did not contact NWAS to transfer the incident service to service. However GMP did contact NWAS to ascertain if the matter had been logged with them. It had not, but no further information was provided to NWAS.

LD who was one of two qualified nurses caring for 18 inpatients on an acute psychiatric ward, did not contact NWAS by the end of her shift.

The following day on the 28th October 2017, AM noted the matter had not been dealt with and asked another nurse, NK to escalate a cause for concern. NK had been on leave the previous week so spent time reading GR's medical notes to understand what had happened. She tried to contact GR and then called his ex-partner.

NK then tried to contact NWAS via 111. The Court heard these calls. Advice was provided to NK that the cause for concern could not be reported via 111 due to a "breach of confidentiality".

At 13.15 hrs NK contacted NWAS via 999. The call was triaged as Grade 3 requiring allocation and response within 120 minutes. At 15.14 hours the Court heard evidence the call had not been allocated and a decision was taken to transfer the call to the Urgent Care Centre of NWAS for a telephone triage.

A telephone call was made to GR at this time by a Registered General Nurse, PR. The Court heard this telephone call. It was accepted by PR that there was a misunderstanding on her part when GR mentioned spending days and nights in the dark. In addition she acknowledged she talked over him when he was starting to say how he was feeling. He did not therefore answer this question. Her evidence was that whilst she did not believe he needed an ambulance she offered transport to hospital, which in her view, he declined.

When this contact was relayed by PR to nurse TC at PCT it was not understood this had been a telephone conversation by NWAS as opposed to face to face assessment.

GR was found hanging at his property the following day.

In order to fully understand the contact between all three agencies and the advice provided it may be useful to the recipients of this Regulation 28 report to listen to all the telephone calls made by the staff on the ground.

The Court also heard evidence from the Deputy Sector Manager from NWAS, the Inpatient Services Manager PCT and a Chief Superintendent from GMP.

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:-

Pennine Care Trust

- The Court heard from the nurses who were tasked to raise a concern for welfare of the practical time difficulties in doing this, given they were working on an acute in-patient psychiatric ward. It was unclear why the clinical lead did not deal with this matter as she was the person to whom the information had initially been provided.

- No-one considered, at any stage the escalation of this incident to the on-call Senior manager when they were having difficulties contacting the emergency services or when GMP had provided the advice to contact NWAS.

- Non of the ward staff were aware of the restrictions on the ward telephones which prohibit 111 calls from being, this meant time was spent trying to make such calls.

North West Ambulance Service

- In cases involving the engagement of Article 2 ECHR there is duty on agencies to investigate the circumstances of the death in order to learn lessons. There was little investigation conducted by NWAS in respect of this case. It was only through the evidence of NK the Court learnt of the existence of the 111 telephone calls she had attempted to make and the information provided to her. In addition until the evidence of PR the Court had not been advised of the removal of the call from the allocation list and the decision made this could be triaged by urgent care.

- The Court heard the calls between NK and NWAS. Advice was provided to NK that a concern for welfare could not be taken by them due to a potential "breach of confidentiality". This led to a further delay in this concern for welfare call being passed to NWAS.

- The decision to remove the concern for welfare call from the allocation list to be triaged by Urgent care meant no face to face assessment was conducted. Moreover the telephone triage call was conducted by a RGN who had limited mental health training.

- The Court heard how the call was graded as a Grade 3 however when taken through the evidence in Court several questions on the triage system had been incorrectly completed.

All three agencies and GMCA

Greater Manchester Police

- There is a lack of acknowledgment of the role of the police when dealing with people who are taken on a Section 136 from their own home. The Court did not explore the numbers of Section 136 patients who are taken to a place of safety from their home address. The Court heard how Mr Rewkowski had been taken from his own home on the 17th September. Other agencies are clearly familiar with this process and how GMP facilitate this. However this was also used as an explanation as to why GMP may have been restricted in what they could do on the 27th and 28th October ie, "*....there is nothing we can do if we attend at his home own. We have no powers.* " There appears to be a significant difference between the legal position and the practical reality of how police deal with such matters if they are called to a home address. This inconsistency is causing confusion amongst other agencies.

- In this case GMP did not call NWAS and asked the nurses to contact NWAS. The Court heard evidence from the Deputy Sector manager for NWAS as to how GMP will contact them to attend concerns for welfare. This was not a process PCT staff were familiar with. This also led to a delay in the call being made.

- Evidence was heard from the Inpatient Services Manager of PCT of their understanding, that the Police are the organisation to call in relation to concerns for welfare (regarding risk to life). The Court heard PCT are still advised the police are the contact. In addition this is the advice within the acute trusts.

- It was clear to the Court from all Senior Managers that there was a distinct lack of understanding across all three agencies of each agencies roles/responsibilities, systems of working and current practices in relation to concerns for welfare involving risk to life (not immediate ie someone in the process of harming themselves). The evidence to the Court was of a confused picture across Greater Manchester with no clear guidance as to how to deal with such matters. Moreover it was apparent there is no documented GM wide process to allow staff on the ground clear information as to how to deal with such matters.

- The Court heard evidence there is no Mental Health Community Response team available to deal with mental health issues out of hours. The only out of hours service is in A&E which would necessitate someone attending there. Evidence was given as to the substantial increase in such issues being reported to GMP. The Court heard how there is now a mental health professional

	within the GMP control room to assist with the calls received. However the main issues are in attending to conduct face to face assessments. The police are the service who have a power to enter property, unlike other services. Therefore whilst they may not be best placed in respect of the assessment they are often called. Given the issue in respect of resources heard throughout this Inquest the Court would question the lack of this Mental Health provision.
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 15th February 2019. 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:- the legal representatives for Mr Rewkowski's family. 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.
-	Date: 28th December 2018 Signed: