REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Ms H Roberts, Chief Executive, Jigsaw Homes Group 249 Cavendish Street, Ashton-under-Lyne, OL6 7AT 2. Dr J Farrar, Chief Executive, HM Prisons and Probation Service , Ministry of Justice, 102 Petty France, London, SW1H 9AJ
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 18th November 2019 I concluded the Inquest into the death of Mr Gary Leyland who died on the 13th November 2018 at [redacted] The medical cause of death was recorded as : 1a) Morphine toxicity The conclusion was Mr Leyland died as a result of suicide.
4	**CIRCUMSTANCES OF DEATH** The accommodation Mr Leyland was residing in was supported accommodation (herein referred to as "Spring Street"). He had been placed in this accommodation following his release from Prison in April 2018. Whilst not directly relevant to the Inquest, Mr Leyland had a number of physical health issues which meant he used a mobility scooter to mobilise. In addition to his physical health issues the Court also heard evidence Mr Leyland had a longstanding history of depression and had on occasions made passing comments referring to there being no point "going on." From April 2018 until the time of his death the Court heard Mr Leyland had a Probation Officer and was subject to supervision. On the 7th November 2018 Mr Leyland was visited at Spring Street by his Probation Officer. She noted he was low in mood and during the meeting he disclosed that he was having thoughts of suicide. He also indicated that the next few months would be difficult for him. Mr Leyland had suffered a number of bereavements the most recent being that of his wife. It was approaching the anniversary of her diagnosis of cancer. Mr Leyland told his Probation Officer there were times when he could, "just take all of his tablets." Whilst the Probation Officer gave evidence to the Court that she did not believe there was an imminent risk to his life the Court found that she clearly had concerns. Her subsequent actions indicated there was a concern as to the risk he posed to himself. When leaving Mr Leyland his Probation Officer spoke to staff at Spring Street to advise them of Mr Leylands presentation. In addition she emailed his allocated worker later the same day. In her email she advised the Spring Street staff of the fact Mr Leyland was of low mood and that he was "thinking of taking a handful of tablets." She concludes the email by advising she will try and get in touch with his GP and asks if they can, "keep an eye on him". The Court heard from Mr Leylands GP that no contact was made with him by any agency. Following the email from the Probation Officer, a Manager at Spring Street increased the checks on Mr Leyland to one per shift ie am, pm and evening. The Court heard evidence that the expectation was that

these checks would be welfare checks and would therefore involve meaningful interaction with Mr Leyland. The Court heard evidence that over the weekend (the 10th and 11th November) any checks would be conducted by the Security staff who were contracted to conduct security checks on the building.

Whist there was evidence before the Court that Mr Leyland was seen on a number of occasions between the 8th and the 12th November 2018 the Court found the majority were not meaningful welfare checks.

On the 12th November the checks were stepped down to once in 24 hours which was the normal observational level. Mr Leyland was found deceased in his room on the 13th November having taken an excess of his prescribed medication.

There was evidence Mr Leyland had intended to end his life.

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:-

National Probation Service

1. Due to the fact Mr Leyland was residing in supported accommodation the Probation Officer reported her concerns to the Spring Street. However no attempt was made to contact any medical practitioner ie GP or mental health services. It was unclear at the conclusion of the Inquest whether there is a policy within the Probation for staff indicating to whom concerns should be raised for example if Mr Leyland had been residing in his own home and where the risk is not believed to be imminent although clearly present.

Jigsaw Home Group

1. Documentation and Recording of Information - during the course of the Inquest the Court was provided with and taken to various documents and records relating to Mr Leyland. The Court found the recording and documentation to be of a poor quality and standard. The chronology document was not complete, information as to when Mr Leyland had been seen was missing. The observational log was completed in some instances with the use of an X as opposed to the staff members initials so it was not clear if he had been seen and if so by whom.
2. Only the handover sheets for the 7th and 8th November were updated to advise staff to "keep an eye" on Mr Leyland. NO updates were on the handover sheets for the 9-12th November despite the evidence being welfare checks would still have been expected on these dates. It is therefore unclear how security staff working the 10th and 11th November (weekend) would have been aware of the expectation to check on Mr Leyland.
3. The fact that the expectation was security staff would be expected to conduct welfare checks at a weekend was heard for the first time in evidence. There was no evidence as to how they are trained, what information is provided to them about self -harm and the risk of suicide. This practice was of grave concern to the Court.
4. The Court heard there was no updated risk assessment conducted as was envisaged following the email from the Probation Service.

Welfare Responsibility and Suicide Prevention

5. The Court heard evidence that Oldham Council who commissioned the supported accommodation through Jigsaw Homes Group. The Court heard evidence part of the contract provision for the service includes the fact that Threshold (the branch of Jigsaw Homes which provided the Spring Street accommodation) must comply with certain policies which included risk assessment and risk management and Safeguarding Adults. However no evidence was provided to the Court as to any self-harm or suicide policy available to staff relating to how they should deal with such issues which may arise. In this case Spring Street clearly took responsibility by virtue of their plan (welfare checks, update risk assessment etc) for Mr Leylands welfare once they were put on notice of the Probation Service concerns. No attempt was made to re-direct the Probation Service to another agency ie Mr Leylands GP nor was any attempt made by Spring Street to contact Mr Leylands GP.

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 Friday 17th January 2020 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 family of Mr Leyland. 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: 20th November 2019 Signed: