REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Secretary of State for Health, Chief Executive of Tameside and Glossop Clinical Commissioning Group (CCG), Chief Executive of Pennine Care NHS Foundation Trust, Greater Manchester Health and Social Care Partnership
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater 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 11th June 2019 I commenced an investigation into the death of Steven Keith Marsland. The investigation concluded on the 18th November 2019 and the conclusion was one of **Suicide**. The medical cause of death was **1a) Hanging**
4	CIRCUMSTANCES OF THE DEATH Steven Marsland had a complex mental health background. He was sectioned under the Mental Health Act for bipolar disorder which had led to a manic episode with psychotic symptoms. On 9th April 2019 he was discharged from the Section 3 and was to reside in the community with support from the Community Mental Health Team (CMHT). He was prescribed sodium valproate. There was one follow up face-to-face meeting with the CMHT on 15th April 2019. There were 4 telephone conversations with the CMHT between discharge and his death on 10th June 2019. On 31st May 2019 he cancelled his appointment for a face-to-face meeting. A further meeting was not arranged. The CMHT did not engage with his family following his discharge from his Section 3. A follow up outpatient appointment with a psychiatrist was not made after his discharge. His family felt he was more withdrawn. On 10th June 2019 he was found suspended from a ligature in a wooded area adjacent to Ashton Golf Club. It was a location known to him through family fishing outings. There were no suspicious circumstances or evidence of third party involvement.
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 inquest heard that his family were very supportive and had attended MDT meetings whilst he was an in-patient. Following his discharge there was no attempt to engage his family and obtain information from them or work with them to support him in the community. There was no clear policy about how a family could be effectively engaged by the CMHT; 2. The inquest heard that he was treated as an in-patient by the Pennine Care team within Stockport MBC. His consultant whilst he was an in-patient was part of the Stockport Team. If he had been a Stockport Resident he would have been discharged under the care of that consultant in the community and had a follow up appointment booked with that Doctor at discharge. However because he was a Tameside Resident at discharge his care moved to the Tameside Borough Pennine Care Team. That meant he had to be allocated to a community psychiatrist based there. That did not happen and no follow up appointment was made; 3. The inquest heard that it was recognised as part of his discharge planning that there should be regular contact in the community with the CMHT. That did not happen and there was no escalation or discussion about the picture of very limited contact as it evolved post discharge.
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 7th February 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 Mr Marsland's parents, 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	**Alison Mutch OBE** **HM Senior Coroner** **13.12.2019**