REGULATION 28: REPORT TO PREVENT FUTURE DEATHS.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted] Medical Director of Greater Manchester Mental Health NHS Trust (GMMH) Trust HQ, Prestwich Hospital, Bury New Road, Manchester M25 3BL • [redacted] Medical Director , Pennine Care Foundation Mental Health Trust (PCFT) Copied for interest to: • The Family of the deceased
1	**CORONER** I am Mr Nigel Meadows – H M Senior Coroner for the Manchester City Area
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	**INQUEST** I concluded the inquest into the death of Kieran Luke Hubbard on the 12th December 2019 and the jury recorded that died from 1a Hanging I came to the Conclusion : **Suicide**
4	**CIRCUMSTANCES OF THE DEATH** The deceased was born on the 16th August 1998 and was found dead on the 8th February 2019 hanging from a ligature made from a metal cable attached to the structure of a building in the process of construction at Vuclan Mill Phase 2, Off Malta Street , Ancoats Manchester A Post Mortem examination confirmed the pathological cause of death to be 1a Hanging Toxicological analysis established the presence of citalopram, venlafaxine and diazepam. All of these were in therapeutic amounts There was a very small amount of alcohol found that this could be due to post-mortem microbial fermentation Following the death a serious incident investigation was carried out chaired by a mental health nurse but not a consultant psychiatrist and no was a psychiatrist recorded as being a member of the review team or from whom advice was sought. Statements were taken from a number of healthcare professionals who had been involved in his care and management and in particular from the consultant psychiatrist who saw him and made important/crucial assessments and decisions about his care and management As a child he was diagnosed

with ADHD and as a teenager began taking a number of illicit drugs His father ran a construction business and was able to provide employment for him The deceased had no fear of heights and was able to work as what is called a "Slinger".

Over a period of some years to suffer depressive disorder was preoccupied or obsessed with suicide At times he could become anxious or distressed and would often phone his father for support and as able to calm him down

On a family holiday in 2017 he appeared to have a mental health crisis and disclosed his father as he contemplated jumping off buildings he was working on Upon returning from this holiday he agreed to seek counselling but was reluctant to engage with other mental health and GP services concerning his overall mental health problems However, he did accept a prescription of antidepressant medication

In November 2018 he and his partner had a son after their relationship began in 2017 However, shortly after the birth this relationship came to an end and he was extremely distressed. His partner had another child from a previous partner and he was concerned about not being able to have contact with both children He experienced difficulties in agreeing arrangements with his former partner to see his son and things came to a head on 26 January 2019 when his former partner cancelled a prearranged contact at the last minute He was very distressed by this later the same day was found on a bridge above the motorway in West Yorkshire contemplating suicide by jumping off it He was detained under S 136 of the Mental Health Act and taken to a place of safety

At this time he was still in employment and had an address in Salford, Manchester but registered with a GP in a different local area a short distance away There are two primary mental health NHS Trusts in Greater Manchester One is called Greater Manchester Mental Health NHS Trust (GMMH). The other is Pennine Care foundation Mental Health NHS Trust (PCFT)

Information was passed to GMMH from local mental health services in Yorkshire and he was seen for the first time 28 January 2019 for an initial assessment in one of the Trusts psychiatric units having attended their voluntarily Thereafter he had intermittent contact with healthcare professionals although agreed that he needed help An experienced consultant psychiatrist working for GMMH first became aware of him as being a patient on 4 February 2019 at an MDT meeting She raised concerns about him driving a motor vehicle when suffering from an acute mental health crisis but understood that there was no clear operational policy dealing with this within the trust This psychiatrist first met the deceased and 6 February 2019 when she undertook a detailed interview and psychiatric assessment She concluded that you suffered severe depressive episode which have been progressively getting worse since December 2018 and marked by recurrent suicidal thoughts

At the time of this interview he denied any current active thoughts of suicide but disclosed that he felt helpless at their frequency and intensity She advised him not to drive at this time was not suitable for home treatment but that he should be admitted to hospital for ongoing assessment and treatment and he indicated that he was willing to cooperate and do this His medication was changed but the psychiatrist concluded that he required aggressive treatment of his depression in a protected and supervised environment Initial enquiries indicated that there was no bed available locally within the GMMH facilities Since he was registered with a GP in what is described as "outside area" which although being a very short distance away was within the catchment area of PCFT. The psychiatrist understood the other healthcare professionals would contact PCF T in order to arrange for him to have a bed at one of their units unless one became available in GMMH. In the interim the deceased indicated his willingness mental health services The deceased discussed his case again

	next MDT meeting on the morning of 8 February The psychiatrist understood that no bed was available but not that the search for a bed had been discontinued or the reasons why but felt that in the absence of an available bed his care could be managed until Monday 11th of February when the position could be reassessed The psychiatrist was not informed on 7 February that GMMH healthcare professionals have been in contact with PCFT but who had apparently requested further information before considering the request bed and those healthcare professionals decided to abandon the attempt to secure a bed because of the deceased's apparent cooperation This was a lost opportunity to have reconsidered the position and pursue other arrangements or escalate the issue On the 8 February the psychiatrist was not updated and told of the accurate position The deceased's father received a phone call from his son mid-morning on that day and he returned the call although was aware from a previous conversation that his son had been advised not to drive a motor car but assured him that he could have the following week off work without any difficulty His parents lived in Norfolk but his father drove to Manchester in order to collect him and take him home for his own welfare and safety En-route to Manchester at about 4 30 PM he discovered that his son posted on Facebook that he was intending to take his own life. He asked his wife to contact GMMH wind and advised to contact the police A concern for the deceased's welfare was raised and his father went to the building site where his working and met police officers at that location at about 6.30 pm and facilitated their entry into the site but also saw his son dead hanging from a ligature understandably extremely distressed and traumatised by what he had seen The police searched the deceased local home and found a number of notes to close members of his family and from those an inference could be drawn that he wished to take his own life Subsequently, GMMH carried out a serious incident investigation produced a detailed report The investigation was chaired by a mental health nurse but did not have a consultant psychiatrist on the investigation team The investigation itself discovered that apparently PCFT wanted further information in order to consider the request bed provided by them but he did not discover exactly what information was requested although this is clearly extremely relevant No contact was made with the appropriate level of management within PCFT to discover this and nor was this issue escalated to senior management within GMMH The report itself which was bound to be disclosed to the deceased's family did not use plain simple English to describe its relevant findings and in particular that the treating psychiatrist had not been made aware of the decision by other healthcare professionals to abandon the search for a bed and so lost the opportunity to make other alternative arrangements which were clinically appropriate In addition to provide the deceased with a safe and supervised environment In practical terms we psychiatrist decision to admit the deceased to hospital was overruled but without advising the psychiatrist and nor was it brought to her attention on the morning of 8 February
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

5 1 The failure by GMMH to expedite the search for and securing an inpatient bed which a consultant psychiatrist has clinically decided was appropriate to provide a safe and supervised environment for ongoing assessment and treatment for a patient with a serious diagnosed mental disorder who had made a very recent attempt to kill themselves This will also require liaison with PCFT because both trusts will come into contact with one another quite regularly

I suggest policies and procedures involved need reviewing and updating as necessary so they work expeditiously when required and also deal with other healthcare organisations that are or may become involved

5 2 There was a failure by GMMH to fully and properly discover and record urgently or in a timely manner exactly what information was apparently required by PCFT in order to facilitate the provision of a bed. Consequently, there was no opportunity to provide that information and secure in bed which may been available when the deceased had agreed to become an inpatient He was therefore out of hospital and not in a safe and supervised location when he killed himself

It is suggested that enquiries of PCFT or any other mental health trust or healthcare provider in similar circumstances needs to be expedited and proper records kept In addition policies, guidance or protocols need to be introduced or updated to deal with this

5 3 The decision to abandon the search for a bed was taken by healthcare professionals without knowledge of exactly what information, if any, PCFT required to consider the request and without updating the psychiatrist in charge of the deceased care in order for them to consider and reassess the position This appears to be a wholly inappropriate and unsatisfactory position

It is suggested guidance, policies or protocols should be introduced to ensure that clinical decisions made by psychiatrists are not overruled or not pursued by other healthcare professionals when the clinical decision had been made as to the care and management of a patient.

5.4 If it is not possible to change or alter the "out of area" catchment area for mental health trusts then GMMH and PCFT should ensure that there are quick and reliable methods of communication between to secure a bed as soon as possible If either trust requires further information this too is communicated quickly, recorded and obtained if possible and the trust seeking a placement can make alternative arrangements urgently.

It is suggested that whatever arrangements currently exist between the trusts they are reviewed and updated and allow for urgent escalation to senior management of either or both trusts

5 5 There did not appear to be any specific guidance , policy or protocol to assist healthcare staff in advising patients to stop driving motor vehicles or using machinery whilst in a mental health crisis (in accordance with any DVLA guidance that exists) which may put themselves or others at risk of death or serious harm

It is suggested that this needs to be reviewed an addressed as soon as possible

5 6 There were failures in the post death investigation process which may result in the true circumstances not being identified and steps taken to prevent continuation or

	recurrence of circumstances which may cause or contribute to a future death It is suggested that the trusts own investigation process needs to be reviewed and amended
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 the 17th March 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 Interested Persons I have also sent it to organisations 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	**DATE:** **NAME OF CORONER:** **Dated : 23rd December 2019** **Mr Nigel Meadows** HM Senior Coroner for Manchester City Area **Signed:**