REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Executive of Greater Manchester Mental Health NHS Foundation Trust, Trust Headquarters, Bury New Road, Prestwich, Manchester,M25 3BL
1	**CORONER** I am Rachel Syed, HM Assistant Coroner for the Coroner Area of Manchester West.
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 the 18th July 2019, I commenced an Investigation into the death of Daniel Jeffrey Moran, born on the 20th November 1986. The Investigation concluded at the end of the Inquest on the 08th January 2020. The medical cause of death was: - Ia. Hanging The Inquest conclusion was, The deceased died as a consequence of injuries sustained from self-application of a ligature. He left notes expressing his intention to end his own life. Despite multiple suicide attempts in the period leading up to his death, he was not deemed suitable to be detained under the Mental Health Act. If the deceased had been detained under the Mental Health Act, he would not have had the opportunity to partially suspend himself from a window on the date in question.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was pronounced dead on the 14th July 2019, at his home address of [redacted] Bolton, having used a rope as a ligature to partially suspend himself from a window. The deceased left goodbye notes expressing his intentions to end his own life. The deceased had a complex medical history including depression and alcohol misuse and had attempted to end his own life on multiple occasions in the period leading up to his death. The deceased was taken to hospital on 11th July 2019 due to a suicide attempt. On 12th July 2019, the deceased was admitted to hospital as a voluntary patient. During

	this period, he became aggressive and agitated and requested self-discharge from hospital. He was assessed as not meeting the criteria to be detained under the Mental Health Act and self-discharged from hospital, contrary to medical advice and was found dead on the above date.
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: During the Inquest, evidence was heard that: - 1. Staff were unaware of the situations where it was appropriate to breach patient confidentiality and notify family or friends, when concerns arose regarding patient safety/welfare. 2. Ward staff needed to have a greater understanding of how to prioritise new admissions and ensure the better flow of patients through the ward 3. Ward staff and ward doctors need to have a greater understanding of each other's roles and responsibilities in relation to managing patient risk and whose responsibility it is to authorise leave and ensuring contemporaneous documentation are kept in relation to the decision making rationale (documenting any changes in risk and capacity). 4. Doctors and ward staff involved in making decisions about self - discharge should consider the circumstances of admission as well as current risks when making decisions around discharge. They also need a greater understanding of the circumstances when it is appropriate to seek more senior opinions in regards to whether the patients meets the criteria to be detained under the Mental Health Act, section 5 (2) and ensuring contemporaneous documentation are kept in relation to their decision making rationale. I request that you undertake a review to ensure staff receive the appropriate training on the issues identified above.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe that 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 **11 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 the following Interested Persons:- 1. [redacted] - Bereaved 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 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	**Dated** **15 January 2020**	**Signed** **Rachel Syed** **HM Assistant Coroner**