REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Constable Greater Manchester Police (GMP) 2. Chief Executive NWAS (NWAS)
1	**CORONER** I am Matthew Cox, Assistant 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 12 October 2018 an investigation into the death of Jason Pendlebury was commenced. The inquest resumed on 9 March 2020 and concluded on 11 March 2020. I recorded a short form conclusion of accidental death.
4	**CIRCUMSTANCES OF DEATH** The Deceased had been a known user of cocaine for several years prior to his death. It is likely that he was under the influence of cocaine when on 29 September 2018 he gained access to the roof area of a block of flats at [redacted] Middleton via a roof window in the bathroom of the flat where he was residing at the time. The deceased was seen to remove slates from the roof and throw them onto the pavement below. He was observed to run across the roof without any apparent regard for his own safety. The deceased appeared to lose his balance and fell from the roof sustaining serious injuries. He was transported by ambulance to Salford Royal Hospital where despite appropriate treatment his condition deteriorated and he died at Salford Royal Hospital on 2 October 2018.
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:- I heard evidence that between 13 August and 22 August 2018 telephone calls were made to Greater Manchester Police (GMP) on 8 separate dates by the Deceased, his wife and his business partner. On all but one of those dates those concerns related to the Deceased's mental health. Of the calls that were made by the Deceased, the call handler reached the conclusion that he had mental health issues. On 3 of the occasions, GMP referred the matter to North West Ambulance Service (NWAS) which resulted in telephone assessments by mental health nurses. The purposes of those telephone assessments was to determine whether an ambulance should attend the Deceased. On two occasions a decision was taken that no ambulance was required. On one occasion an ambulance was dispatched although the deceased refused medical assistance and was not taken to Hospital. It was not clear from the evidence that the mental health nurses carrying out the telephone assessments were aware of the number of calls that had been made to GMP or of the previous telephone assessments. None of the calls made to GMP or the fact that telephone mental health assessments had taken place was communicated to the Deceased's GP. This meant that when the Deceased's wife contacted the GP on 6th September 2018 with concerns about his threats of suicide, the GP did not have all the information that he

	might of had to determine what action to take. I also heard that a Multi-Agency Adult Care Safeguarding Team meeting was held at Rochdale Police Station on 28th August 2018. The Approved Mental Health Professional (AMHP) who attended that meeting was not provided with the full details of the telephone calls that had been made to GMP regarding the Deceased's mental health and consequently assessed the risk of harm to himself and others as low. Had the AMHP been provided with full information, it would have automatically generated a referral to the Single Point of Access and led to the involvement of the mental health services. A further contact with GMP was made on 19th September 2018 and I heard that this triggered a referral to the mental health services. However, GMP were unable to confirm what had happened to the referral and the Mental Health Trust confirmed that they had no knowledge of any referral being made. In addition, GMP did not notify the Deceased's GP that a referral to mental health services had been made. The matters of concern relate to the quality and systems of communication regarding concerns relating to potential mental health needs between GMP and NWAS and onward communication to General Practitioners and Approved Mental Health Practitioners tasked with assessing risk levels.
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 12 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 namely:- [redacted] Chief Executive Pennine Care NHS Trust (PCT) Director General Independent Office for Police Conduct (IOPC) 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: 12 March 2020 Signed: