	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Gillian Keegan MP** **Minister of State (Minister for Care and Mental Health)** **Department of Health & Social Care**
1	**CORONER** I am Alan Anthony Wilson Senior Coroner for **Blackpool & Fylde**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** The deaths of Marshall Metcalfe on 07/05/20 and of Jane Ireland on 07/06/20 were reported to me and I opened investigations on 09/12/20, which concluded by way of an inquest held between 15/11/21 and 25/11/21. I determined that the medical cause of Marshall's death was: **1 a Multiple injuries, due to** [redacted] I determined that the medical cause of Jane's death was: [redacted] **2 Bronchopneumonia** The conclusion of the Coroner was that Marshall died due to [redacted]. The conclusion of the Coroner in Jane's inquest was a Narrative conclusion which reads as follows: **At a time when she was grieving following the death of her Son, Jane Ireland died after she** [redacted] **in combination with fatty liver disease, proved fatal.**
4	**CIRCUMSTANCES OF THE DEATH** In box 3 of the Record of Inquest for Marshall, I recorded as follows: **Marshall Metcalfe was known to mental health services. He had twice been admitted to a Tier 4 (Inpatient) Child & Adolescent Mental Health facility , most recently in February 2019 after an apparent relapse of his illness, complicated by physical health difficulties that had required a hospital admission. He had been diagnosed as suffering from psychosis. Marshall was known to be someone who would refuse to engage in almost any social interaction. He**

	was discharged on 06/01/20 and he returned to reside with his Mother. This was a decision clearly made with the support of Marshall and his Mother. By the time he was discharged minimal progress had been made and his lack of engagement persisted. An alternative placement was not considered, largely because of his desire to return home and to a supportive family. Children's social care were unable to contribute to discharge planning having not been notified about Marshall's discharge for approximately two months afterwards. No risk assessment had been completed. Following discharge, Marshall continued to take his prescribed Clozapine medication. Over subsequent weeks his presentation remained stable although his weight did noticeably increase which is a known side effect of that medication. Following discharge, he was not seen by a community psychiatrist at a planned review on 19/03/20 as a result of coronavirus restrictions in place at that time. At around 12 noon on 07/05/20 he was seen to leave home. [redacted] Marshall was transferred by ambulance to the Royal Preston Hospital but had received catastrophic injuries and his death was verified at 14:33 hours that afternoon. In box 3 of the Record of Inquest for Jane, I recorded as follows: **Jane Ireland was known to have had a history of mental health issues, although in recent years she had been largely stable, and save for a relapse in early 2019 when she had stopped taking her medication and in December 2019 when she went to see her own GP and was referred to START, she experienced no major relapses or acute episodes. On 7th May 2020, Jane's seventeen year old Son died. Having been seen at her home address on 6th June 2020 when she is reported to have been in good spirits, Jane was found deceased in her bed by a friend at her home address on 07/06/2020. A paramedic attended and verified her death at 16:00 hours. A subsequent post mortem examination revealed that Jane had, during the hours prior to her death, [redacted] the toxic effects of which, in combination with fatty liver disease, proved fatal. Her death was more than minimally contributed to by bronchopneumonia identified at post mortem. From the available evidence it cannot be established whether Jane intended to end her life.**
5	**CORONER'S CONCERNS** During the course of the inquests, the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – This report relates to two inquests. They were held jointly after I acceded to a request from the bereaved family that the inquests be conducted together. As will have been noted from section 4 above, both Marshall Metcalfe and his Mother, Jane Ireland, were known to mental health services. The concern I wish to raise emanated from Marshall's death. He had been admitted to a mental health facility in February 2019 and remained there until he was discharged on 06/01/20 to his Mother's home where he resided until his death on 07/05/20. One month later, his Mother Jane died at her home on 07/06/2020.

	The court heard that when Marshall was in the mental health facility during what was his 2nd admission, a decision was made to discharge him from children's social care. He had been supported as a Child in Need [under section 17, Children Act 1989] for 28 months, and this continued for a large part of that admission until 14/10/19. In September 2019, a decision had been taken by Children's Social Care to cease their involvement as no role could be identified for a statutory social worker at that time. Any home leave had been suspended indefinitely, and there were no definite plans for Marshall to be discharged. However, a request was made that in the event the decision about home leave were to change, or if discharge was to be considered likely for Marshall, then Children's Social Care would again have a role and a re-referral should be made. In fact, Marshall was discharged on 06/01/20, there being no evidence before the court that such a re-referral had in fact been received by Children's Social Care by then and it follows there had been no social worker input into Marshall's discharge planning. At the inquest, the court received evidence [from Marshall's Responsible Clinician, Consultant Child & Adolescent Psychiatrist, Dr [redacted]] that in his experience when patients are admitted to the facility Children's Social Care will close their case for the patient, and that when the patient is later ready for discharge a re-referral becomes necessary. He also reminded the court that throughout a patient's admission, consideration is being given to discharge in line with the recommendation of NHS England that all admissions should be kept as short as possible and the expectation that there should be discussion about discharge at every Care Programme Approach (CPA) meeting. Another witness, [redacted], a former Inpatient Social Worker at the facility with 25 years of experience as an Approved Mental Health Professional, told the court that in his view when such a re-referral does become necessary it is like "starting from scratch" and causes immense problems building trusting therapeutic relationships with young people. He felt that there should be continual input from social care during the patient's admission, and that in the event that there has been no social worker input into a patient's discharge this raises the risk for that person once they leave the facility. I also instructed Dr [redacted], a Consultant Child and Adolescent Psychiatrist, to provide an independent expert opinion on the care provided to Marshall. In her evidence she shared the concerns of Dr [redacted] and [redacted] and described this as "a wider issue" that was not confined to this case. The issue that I raise is as follows: I share [redacted] concern, echoed by Dr [redacted], and ideally social care not closing their case, but remaining involved throughout a patient's admission would be helpful. It may be that they would play a minor role, if any, whilst the patient remains in hospital until discharge is felt to be a genuine prospect, but once their input does become necessary they would be more able to respond quickly and to actively participate in discharge planning without the need to wait for the re-referral process to be carried out, thereby ensuring that the effectiveness of role played by social care in discharge planning is not compromised. In Marshall's case, I found that there was no evidence that shortcomings in relation to discharge had materially contributed to his death, but I feel that this issue does pose a risk of deaths in the future, and that it is my duty to write this report.
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 Friday 21st January 2022. 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: • [redacted] [Sister of Marshall / Daughter of Jane]; • Lancashire & South Cumbria NHS Foundation Trust; • Lancashire County Council; • Blackpool Clinical Commission Group / Fylde & Wyre Clinical Commissioning Group 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, 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	25/11/2021 Signature_____ Alan Anthony Wilson Senior Coroner **Blackpool & Fylde**