REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Secretary of State for Health and Social Care Greater Manchester Health and Social Care Partnership
1	CORONER I am Anna Morris, Assistant Coroner for 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. 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 An inquest was opened on the 26th November 2020. The inquest was heard between the 17th and 21st January 2022. The medical cause of death was recorded as- 1a Multiple Injuries The conclusion of the inquest was suicide.
4	CIRCUMSTANCES OF THE DEATH Matthew was 36 years old at the time of his death. Matthew had struggled with his mental health throughout his adult life. In 2020 his mental health deteriorated leading to a number of crisis presentations to hospital in April and May for assessment under the Mental Health Act. He was diagnosed with a Personality Disorder which was characterised by his changeable presentation, difficulty in regulating his emotions and his experience of

becoming distressed, being impulsive and having intrusive thoughts of self-harm and suicide. Matthew had been a heroin user in the past but had not used heroin for over a decade and was prescribed opiate substitutes.

On the 22nd July 2020 Matthew was sentenced to a Community Rehabilitation Order and was subject to supervision by probation. In August he was referred by probation to the Salford Criminal Justice Team provided by Greater Manchester Mental Health Trust. Matthew was also seeing a Substance Misuse worker at Achieve and by August 2020 had started sessions aimed at a full detox from Subutex. He was also referred to the Community Mental Health Team. They assessed Matthew in September 2020 and referred him to a community-based psychiatrist. The assessment determined that Matthew did not require the Care Programme Approach and therefore he was not allocated a Care Coordinator.

On the 29th October, there were concerns about Matthew's behaviour. Police attended and took him to hospital to be assessed under the Mental Health Act. He was then discharged back to police custody. Whilst in police custody between the 30th October and 2nd November Matthew made repeated threats to his own life.

Matthew appeared before Magistrates on the 2nd November, where he was made subject to bail conditions that restricted his access to entering the area where his children lived and from having contact with their mother. Family and particularly his children were very important to Matthew. Later on, the 2nd November, Matthew presented as very distressed to his probation officers. They were concern about the risk he presented to himself had increased and were aware that one of his protective factors, namely his children had been impacted by his bail conditions, they conveyed him to hospital for assessment by the Mental Health Liaison Team. He was seen but not assessed as requiring an inpatient admission under the Mental Health Act. As a result of his bail conditions, Matthew lost an allocation of housing that he had been looking forward to moving into near friends and family. This would likely have had a further impact of Matthew's mental health.

On the 5th November 2020 Matthew had a conversation with a Children's Social Worker from which it is likely that he believed that his access to his children would need to be supervised. This is also likely to have had an impact on Matthew's mental health.

On Monday 9th November 2020, Matthew was of no fixed abode and had been staying with friends in the Stockport area. He contacted his substance misuse worker to find out when their next appointment was.

During that conversation, Matthew told her that he was thinking about going to buy heroin to end his life. His worker reminded him of protective factors and of their future appointments. Matthew then spoke to his

probation officer, and repeated that he had thought about buying heroin to end his life, but he expressed an intention to keep attending appointments and said he did not now have any intention to buy substances. His Probation Officer later sent him by text the details of temporary accommodation in the North Manchester Area. Matthew also spoke to his mother. She was concerned about him because of texts they had exchanged over the weekend in which Matthew had indicated that he was low in mood and said that he was 'done'.

At 19:50 Matthew was seen on CCTV attending [redacted] in South Manchester. He entered the [redacted] at 19:53 and began to walk on the Manchester [redacted]. At 19:56 Matthew was [redacted] travelling at speed. Matthew sustained multiple injuries and died at the scene. Toxicological analysis confirmed the use of prescribed medication use before death including Buprenorphine.

I must determine whether Matthew intended to take his own life. I do so on the balance of probabilities. I take into account his diagnosis of personality disorder, his fluctuation in presentations and his impulsivity. The description of his mood on the 9th November by his mother and Ms. Foley, combined with his historic pattern of intrusive thoughts of suicide and suicidal acts, and the evidence from the CCTV footage. The CCTV evidence showed that Matthew attended a [redacted] within 3 minutes of arrival and that prior to entering the [redacted] he allowed himself to [redacted]. I also find that Matthew is likely to have been aware of the sound of the [redacted] that ultimately [redacted]. I therefore conclude on the balance of probabilities that Matthew intended to take his own life.

I find that although there were a number of agencies in contact with, working with or supporting Matthew, including probation, the Criminal Justice Liaison Team, Achieve, Salford City Council Housing Services and Salford City Council Children's Services there was no co-ordinated approach to his care and support and there was no single agency or person co-ordinating the planning of his care and support across the relevant agencies.

I find that although there were examples of good communication between some agencies, there was a lack of a holistic and co-ordinated approach to Matthew's needs and that this co-ordinated approach could have led to a fuller understanding by those agencies as a whole of the risks he posed to himself, particularly from the 29th October onwards and an opportunity to put in place an effective risk management plan. Therefore, this lack of a co-ordinated approach possibly made a more than minimal contribution to his death.

Conclusion: Suicide

5	CORONER'S CONCERNS The MATTERS OF CONCERN are as follows. – Matthew McManus had complex mental health and social care needs. He was in contact with a significant number of agencies many of which focused on the risk that Matthew posed to others. However, the evidence before me, particularly that of the Salford Safeguarding Board indicates that no -one saw Matthew as the vulnerable adult he was and addressed how his own complex needs were to be met, either through a Care Act assessment or any other means. [redacted], on behalf of the Safeguarding Board who conducted a Safeguarding Adult Review told the Inquest that there was no one person or agency co-ordinating his support and care, meaning that Matthew did not have a single point of contact to help him understand and navigate the services being offered to him. This became particularly concerning when Matthew's mental health declined, making him more erratic and difficult to contact. This left already stretched services to do what they could to pull information together from their own resources or conversations with other agencies. Without proper co-ordination, there was no full information sharing, joint assessment, or joint planning of Matthew's support, which meant there was never a full appreciation of the risk he posed to himself, and no real care plan was in place to manage that risk. Without a clear pathway for agencies to jointly assess and co-ordinate care in the case of adults with complex mental health and social care needs, I am concerned that future deaths will occur. A copy of the SSAB Safeguarding Adult Review can be found at this link https://safeguardingadults.salford.gov.uk/media/1291/version-for-publication-ssab-discretionary-sar-mathew.pdf
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 11th February 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 The family of the deceased, National Probation Service, Salford City Council, Greater Manchester Police and to the LOCAL SAFEGUARDING BOARD. I have also sent it to Dr. [redacted] (Little Hulton Health Centre) 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	11th February 2022 Signature  Anna Morris HM Assistant Coroner for Greater Manchester South