REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **Secretary State of Health and Greater Manchester Health and Social Care Partnership.**
1	CORONER I am Alison Mutch , Senior Coroner, for the Coroner Area of 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
3	INVESTIGATION and INQUEST On 25th March 2020 I commenced an investigation into the death of Martin Gibbons. The investigation concluded on the 22nd April 2021 and the conclusion was one of suicide. The medical cause of death was 1a Hypovolaemic shock, 1b Neck laceration

4	CIRCUMSTANCES OF THE DEATH Martin Anthony Gibbons attempted to take his own life on the morning of 19th March 2020. He had at times in the days previously displayed symptoms consistent with a deterioration in his mental health. He was taken to Tameside General Hospital. He was assessed as requiring treatment for the wounds he had inflicted on his arms with a knife and assessment by the mental health liaison team. The assessment by the mental health liaison team identified he needed to be admitted to a psychiatric ward. He agreed to that and had he not agreed the mental health team would have sought to section him under the Mental Health Act. He was left at Tameside General Hospital in the designated mental health room whilst a bed was sought for him. At the time he was left there was a failure to conduct a detailed risk assessment for the period whilst a bed was sought or to agree a joint plan to manage the risk. It is probable that failure contributed to his death. Martin Gibbons left room 14 saying he was going to the toilet. Whilst unobserved he left the hospital. He purchased a Stanley knife just over an hour later in Stalybridge. A full search by Tameside General Hospital staff and Greater Manchester Police was unsuccessful until 24th March 2020.

	On 24th March 2020 he was found in a secluded area of Stamford Golf Course. There were no suspicious circumstances and no evidence of third party involvement in his death. Post mortem examination confirmed he was not under the influence of any substance at the time of his death and that he had died from a self-inflicted neck laceration.

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. – 1. During the course of the inquest evidence was heard that the acute and mental health trusts involved had assessed the level of risk he presented differently in part due to there being no shared definition of risk or the factors that triggered a patient being treated as high risk. The inquest heard that across the NHS there is in relation to mental health no shared definition between acute and mental health trusts of what constitutes a high risk patient. The two trusts involved in this inquest had since Mr Gibbon's death identified that as an issue and work was underway between them to develop and implement a shared definition locally in the absence of any shared national definition. 2. The inquest heard evidence that since Mr Gibbon's death both trusts had recognised that to reduce risk there needed to be detailed and documented shared risk assessments and care plans for patients such as him in an acute setting. The inquest heard that there was no national or regional guidance in place in relation to this shared care plan approach. 3. It was during the prolonged wait in the Emergency Department for a mental health bed that Mr Gibbons left. The inquest heard that this wait was contributed to by a number of factors in particular • A national lack of mental health beds; • The fact that although he had presented to Tameside Hospital and had been assessed by Pennine Care staff because he was a resident of a neighbouring borough covered by a different NHS Mental Health Trust that other Trust had to be contacted ,given all of the information and find him a bed. The inquest was told that this was as a result of how services were commissioned and that the workers who had assessed him had no choice other than to follow this process notwithstanding the additional delay it created.
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 **16th July 2021**. 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] (family of deceased) and [redacted] (family of deceased), 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	**21st May 2021**  **Alison Mutch HM Senior Coroner Manchester South**