REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Chief Executive of Pennine Care, the Chief Executive of Tameside and Glossop Clinical Commissioning Group (CCG)
1	CORONER I am Alison Mutch, Senior Coroner, for the coroner area of South Manchester
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 14th November 2017 I commenced an investigation into the death of John Paul Derwent. The investigation concluded on the 24th May 2018 and the conclusion was one of **Suicide**. The medical cause of death was **1a) Hanging.**
4	John Paul Derwent was on the waiting list for cognitive behavioural therapy. The target time for being seen was 6 weeks. At the time he was referred, the waiting time was 12 months. He expressed suicidal ideation and was admitted as a voluntary patient to the Arden Ward. He found the environment exacerbated his agitation. He was discharged into the community on 8th November 2017. The Home Treatment Team saw him on 10th and 11th November 2017. On 13th November 2017 he was found suspended from a ligature at his home address, 13 Stephens Road, Stalybridge.
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. –

	The Inquest heard that the target time for an appointment for CBT should be 6 weeks. At the time Mr Derwent was referred, the waiting time was 12 months. There was a waiting list review in October 2017 when it was established that 500 people were on the waiting list for CBT. The waiting list time at the date of the Inquest remained 12 months. The Inquest heard that there was insufficient capacity for the number of people referred for CBT which is why the waiting list had become so significant. It was unclear why the list had been allowed to increase to this level. The mechanisms for escalation between the commissioning body and the service provider did not appear to allow for early action to address the issue.
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 30th July 2018. 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] 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	**Alison Mutch OBE** **HM Senior Coroner** **04/06/2018**