REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted]**Head of Clinical Services -** **TRU (Transitional Rehabilitation Unit), Margaret House, 342 Haydock Lane, Haydock, St Helen's, Merseyside WA11 9UY**
1	**CORONER** I am Rachel Galloway, Assistant Coroner, for the coroner area of Greater Manchester West.
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 the 2nd January 2019 I commenced an investigation into the death of David Richard Fowler. An inquest was opened on the 4th January 2019. The investigation concluded following a 5-day inquest at Bolton Coroner's Court on the 20th December 2019 and the conclusion was one of Suicide. The Medical Cause of Death was 1a Multiple injuries.
4	**CIRCUMSTANCES OF THE DEATH** David Fowler ("David") had a significant history of mental illness. From around 1999, David had developed problems with both illicit drugs and alcohol consumption. In or around 2003, David suffered a significant brain injury due to an assault. That brain injury caused or seriously exacerbated a Personality Disorder. The combination of the brain injury and Personality Disorder meant that David was impulsive and his alcohol and drug misuse problems became more extensive and difficult to manage. In April 2017, David was referred to and accepted for specialist rehabilitation at the Transitional Rehabilitation Unit ("TRU"), which was funded by the local Clinical Commissioning Group. At this stage, David was resident at Newton Unit (a locked rehabilitation unit) and detained under section 3 of the Mental Health Act 1983. He later spent time at Lowton Unit (an open rehabilitation ward) before moving to Ashton Cross on the 12th March 2018. Ashton Cross was a pre-community placement. David remained under section 3 of the Mental Health Act 1983 but had been granted section 17 leave with a condition that he reside at Ashton Cross. Throughout his time at TRU, David received significant therapeutic input including help with problem solving and impulsivity, counselling and planning. There were periods where David showed improvement and other periods where he would abscond from the various units and consume alcohol and illicit drugs. On the 18th December 2018, an inappropriate decision was taken (following a Multidisciplinary Disciplinary Team Meeting ("MDT")) that David's "section 3" (and parasitic "section 17" provisions) would be removed. It was the view of the instructed expert Psychiatrist that the "section" should not have been lifted until there was a plan in

	place regarding his community placement and care going forward. As a result of the decision of the Responsible Clinician at the MDT, David became a resident at Ashton Cross with no legal framework in place and with no community plan in place for his future. The views of David's family were not sought prior to the decision to lift the section on the 18th December 2018. Further, David's family was not invited to attend the MDT meeting on the 18th December 2018. David left Ashton Cross on the 20th December 2018 and was returned by police on the 23rd December 2018. David had consumed alcohol and drugs during this period and been arrested for a criminal offence. His behaviour was escalating but the lack of any legal framework meant that TRU had limited control over him. On the 26th December 2018, David left Ashton Cross at 1.30 pm with the intention of placing a bet on the races. He was a voluntary client at Ashton cross and was entitled to come and go as he pleased. At approximately 3 pm David fell backwards from a motorway bridge at junction 24 of the M6 from the A58 (Liverpool Road). In the moments prior to taking those actions, David likely formed an intention to end his own life by falling from the bridge. He had not formed any specific intention to end his own life prior to that. David died as a consequence of multiple injuries sustained after he fell from a Motorway Bridge, with the intention of ending his own life. The inappropriate decision to revoke his detention under section 3 of the Mental Health Act 1983 (eight days prior to his death) likely contributed to his death. This was the evidence of Professor Shaw, expert Psychiatrist. I accepted her evidence on that point. Further, there was a failure invite David's family to that MDT meeting (8 days prior to his death) but this did not contribute to David's death.
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. – In David's case, no steps were taken to invite [redacted] (or any other family member) to the MDT meeting on the 18th December 2018 when the decision was made by the Responsible Clinician to remove David from the confines of section 3 (and section 17) of the Mental Health Act 1983. It is a requirement of the Mental Health Act 1983 that the nearest relative is informed. Further, family views were not sought regarding the decision to lift the section in any other way. At the inquest, staff remained unclear between themselves as to whose responsibility it was to inform the family. Whilst I was informed that a Policy has been drafted and is in the process of being ratified, it remained the case that there was no formal Policy in place covering contact with families in respect of the above decisions and/or in respect of inviting family members to MDTs more generally. I was further concerned that there was on-going confusion between witnesses (in particular the Acting Manager and the Responsible Clinician) as to who is tasked with informing the family of MDTs and of any potential decision to remove a "section".
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 **17th February 2019**. I, the Assistant 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 the following Interested Persons (as well as the funding Clinical Commissioning Group for TRU) who may find it useful or of interest: (1) [redacted] (through BJC Solicitors) (2) Liverpool County Council (3) 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 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 assistant coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Dated 20th December 2019**
	Signed: **Rachel Galloway** **HM Assistant Coroner** **Manchester West**