REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Mayor of Greater Manchester and the Chair of Trafford Clinical Commissioning Group.
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 19th October 2017 I commenced an investigation into the death of Andrew Reid. The investigation concluded on the 5th April 2018 and the conclusion was one of suicide. The medical cause of death was hanging.
4	CIRCUMSTANCES OF THE DEATH On 17th October 2017 Andrew Reid was found suspended from a ligature at Longford Park, Edge Lane, Stretford.
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. The inquest heard that when Mr Reid went to see his GP she was very concerned about the risk he posed to himself and wanted him to be seen urgently by the Home Based Treatment Team (HBTT). The initial call was to the Manchester team -because the GP practice was within the City Of Manchester-who accept referrals from GPs. The Manchester HBTT are commissioned to provide a 24/7 Urgent Assessment Team that GPs can refer into. However, as Mr Reid was a Trafford resident the referral was not accepted and the GP called the Trafford HBTT. Under the terms of their commissioned service they cannot accept referrals from GPs and contact is via the CMHT (office hours weekdays only) or via the

	RAID team in A and E. In this case that meant Mr Reid was told he would have to go to A and E. The inquest was told that the differences in level of provision for those with mental health are based on the decisions made by each commissioning authority. As a result residents of GM with mental health issues have a different level of support and route to access services. 2. In Trafford the outcome of the commissioning is that there are no emergency GP referrals dealt with OOH. They can only be dealt with Monday to Friday by the CMHT. GPs outside these times dealing with emergency mental health issues for Trafford residents have to ask patients to make their way to A and E for assessment. If they are concerned that a patient may not make it to And E then they have to ask the Police to check with A and E -as happened in the case of Mr Reid
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 5th June 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] wife of the 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	Alison Mutch OBE HM Senior Coroner 10.04.2018