REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Royal College of Psychiatrists, 21 Prescot Street, London, E1 8BB 2. Secretary of State for Health, The Rt Hon Steve Barclay MP, 39 Victoria Street, London, SW1H 0EU
1	**CORONER** I am Ms Joanne Kearsley, Senior Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 7th July 2022 I concluded the Inquest into the death of Stanislav Mucha who died on the 3rd February 2021 at Salford Royal Hospital. The medical cause of death was recorded as : 1a) Polytrauma The conclusion was a narrative conclusion – Died as a result of catastrophic injuries sustained after he jumped from the [redacted] at the Rock centre in Bury. There was no evidence of his intention and he had a history of psychosis.
4	**CIRCUMSTANCES OF DEATH** Stanislav was 17 years old when he died on the 3rd February 2022. In concerns had been raised about his mental health and he was admitted as an inpatient. He was diagnosed with acute on-set psychosis. He was discharged from hospital in May 2020 and his care was passed to the Early Intervention team. Stanislav presented as a high risk to others. He travelled to Slovakia with his family in September 2020 and he returned in January 2021. At this time there had been a clear deterioration in his mental health. There are repeated attempts to engage him and referrals for a mental health act assessment. On the 22nd January the court heard that a mental health act assessment was attempted at the home address. In attendance was a Section 12 approved independent psychiatrist, a Consultant Psychiatrist from the treating trust, the Approved Mental Health Practitioner and a professional who was involved in sourcing a bed for Stanislav. All members of this group gave evidence to the court as to what they understood had occurred on this day. There was a difference in opinion as to whether :- a) A mental health act assessment had been conducted. The psychiatrists were of the opinion due to the brevity of time in which Stanislav was observed, merely walking past them into the house, an assessment was not done. This was at odds with the AMP who believed an assessment had been conducted. b) The next steps which were to be taken. Three of the professionals understood an application to the Magistrates court for a Section 135 warrant to allow entry into the property. This was not the understanding of the AMP who did not progress this action, having formed the opinion an assessment had in fact taken place. The Court heard evidence the Psychiatrists were expecting a further attempt to conduct an assessment later that day or the next day. On the 26th January 2021 Stanislav's treating Consultant Psychiatrist became aware of the outcome of the mental health act assessment. Due to ongoing concerns in relation to Stanislavs mental health a further mental health act assessment was arranged for the 3rd February 2021. Stanislav jumped [redacted] of the 3rd February 2021.

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 Independent Section 12 Consultant Psychiatrist did not make and the court heard does not have the facilities to make any notes in relation to the assessment. 2. Following the assessment on the 22nd January 2021 there was no documented agreement as to the outcome of the assessment between all professionals. This would have negated the confusion and lack of understanding as to what had occurred and the actions required. 3.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 Friday 30th September 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 namely:- the family of Mr Mucha. 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 from. 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.
-	Date: 4th August 2022 Signed: