REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The Rt. Hon. Steve Barclay MP, Secretary of State for Health and Social Care, Department of Health and Social Care, 39 Victoria Street, London, SW1U OEU

CORONER

I am Chris Morris, Area Coroner for Manchester South.

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 1st April 2021, Andrew Bridgman, Assistant Coroner, opened an inquest into the death of Mr Christopher Michael Lloyd, who died at his home on 14th March 2021, aged 32 years. The investigation concluded at the end of the inquest which I heard between 15th – 17th August 2022.

In the light of a Post Mortem examination, the inquest determined that Mr Lloyd died as a consequence of hanging. The conclusion of the inquest as to Mr Lloyd's death was one of Suicide.

CIRCUMSTANCES OF THE DEATH

Mr Lloyd died at his home having suspended himself by the neck with a ligature.

Mr Lloyd had a long history of poor mental health, and considered himself to have Post Traumatic Stress Disorder. He also had a significant history of substance misuse, and at various points throughout his life had been known to use alcohol, cocaine and cannabis in a potentially detrimental manner. Mr Lloyd had also been known to take [redacted] although these medicines were not prescribed to him.

At the time of his death, Mr Lloyd's key treatment goal was to be abstinent from all substances and to have an assessment of his mental health.

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 **MATTER OF CONCERN** is as follows. –

1. Whilst Mr Lloyd had some interactions with mental health services, and was under the care of a charity who provides support as a consequence of alcohol and drug addiction, it is a matter of concern that he did not have ready access to a dual-diagnosis service locally.

A unified service of this nature, employing appropriate specialists, would have the benefit of being able to assess and treat mental-health conditions existing alongside substance misuse issues in a coherent and holistic manner.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 21st October 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

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to [redacted] on behalf of Mr Lloyd's family. I have also sent a copy to Pennine Care NHS Foundation Trust and Greater Manchester Police as other Interested Persons to the case.

I have sent a copy of my report to the Tameside Metropolitan Borough Council, Change Grow Live (My Recovery, Tameside) and Greater Manchester Health and Social Care Partnership, 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.

Dated: 26th August 2022

Signature: 

Chris Morris HM Area Coroner, Manchester South.