REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **███████, Chief Nurse and Director, Greater Manchester Mental Health NHS Foundation Trust, Trust Headquarters, Bury New Road, Prestwich, Manchester M25 3BL**
1	**CORONER** I am Nicholas Leslie Rheinberg, assistant coroner for the coroner area of Lancashire and Blackburn with Darwen
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 21st May 2020 an investigation was commenced into the death of Daniel Robert Nelson aged 37. The investigation concluded at the end of the inquest on 12th September 2022. The conclusion of the inquest was that the deceased died as a result of heroin toxicity, that his death was drug related and that failings of the Trust in relation to among other things, section 117 obligations, contributed to the death.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a long history of a dual diagnosis of schizophrenia and drug dependency. Following years of homelessness and imprisonment he was sectioned under section 3 of the Mental Health Act 1883 ("the Act") and received treatment in the Eagleton Ward of the Meadowbrook Unit in Salford. He was discharged from section 3 care with an inadequate discharge plan and the requirements of section 117 of the Act were not met. He was housed in unsuitable emergency accommodation, without adequate support, in circumstances where he had access to drugs and subsequently died as a result of an accidental heroin overdose. The evidence revealed that with proper discharge planning and care his death would probably have been avoided. Staff on the Eagleton Ward had insufficient knowledge in relation to discharge planning and duties, particularly where, as in this case, the discharge was to an area outside Manchester. Within the Trust there was no protocol, policy or adequate standard operating procedures governing section 117 discharges
5	<u>**CORONER'S CONCERNS**</u> 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. – Within the Trust there was no protocol, policy or adequate standard operating procedures governing section 117 discharges

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 8th November 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 through their legal representatives: [redacted] the Probation Service, Lancashire and South Cumbria NHS Foundation Trust and Greater Manchester Mental Health Foundation Trust. 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	**Dated 12th September 2022** **SIGNED *Nicholas Rheinberg*** **Assistant Coroner**