REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive of NHS Greater Manchester Integrated Care
1	**CORONER** I am Catherine McKenna, Area 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 4 May 2022 an investigation into the death of James Alan Tice otherwise known as Alan Tice was commenced. The investigation concluded at the end of the inquest on 31 August 2022, I recorded a conclusion of Suicide. The medical cause of death was recorded as 1a) Hypovolemic shock 1b) bleeding from deep cuts [redacted]
4	**CIRCUMSTANCES OF DEATH** Mr Tice was 75 years of age when he took his own life at his home address. He had a diagnosis of recurrent depressive disorder with anxiety features and had suffered with this condition for most of his adult life. He had numerous informal admissions to psychiatric hospitals and most recently was discharged from Birch Hill Hospital in Rochdale in February 2022 following an 8 month admission. Following his discharge from hospital, Mr Tice remained under the care of the Home Intensive Treatment Service and the Consultant Psychiatrist. By 26 March 2022, it became apparent that he was experiencing a further relapse in his condition. A request for a hospital bed on an informal admission basis was made on 6 April 2022. The first bed that became available for an older adult was on 28 April 2022 which was the day that Mr Tice took his own life. In addition to the lack of an available bed, the evidence was that Mr Tice required psychotherapy of a type that was over and above the service provided by mental health practitioners offering psychological support on the ward and in the community. The evidence was that a vacancy for the post of in-patient psychologist at Birch Hill Hospital has remained unfilled for a number of months and that a psychotherapy service of the nature required by Mr Tice is not available in the community.
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) Availability of beds for patients requiring an informal admission to an older adults mental health ward in the area covered by Pennine Care NHS Foundation Trust (2) Availability of psychotherapy services for older adults in the community whose needs exceed the service available through Thinking Ahead.
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 **1 November 2022** I, the Area 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] • Pennine Care NHS 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 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: 5 September 2022 Signed: