REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Head of Patient Safety of Pennine Care NHS Foundation Trust
1	CORONER I am Anna Morris, Assistant Coroner, for the Coroner Area of Greater Manchester South
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 (Investigation) Rules 2013.
3	INVESTIGATION and INQUEST On 11th March 2022 an investigation was commenced into the death of Carl Garry Thompson. The investigation concluded on the 17th February 2023 and the conclusion was one of **Drug-Related Death.** The medical cause of death was **1a) Drug Toxicity; 2) Hypertensive Heart Disease**
4	CIRCUMSTANCES OF THE DEATH At the time of his death on the 9th March 2022, Carl was on s.17 Mental Health Act (MHA) leave from the Arden Ward, Stepping Hill Hosptial where he was detained under s.3 MHA. Carl had been granted leave by his Responsible Clniican on the 4th March and his leave commenced on the 7th March. He was granted 5 days overnight leave and should have returned to the ward on the 11t March. The jury made the following findings in relation to the circumstances of Carl's death: Carl Thompson was found unresponsive in the bedroom of his house at 01:00 by his daughter on 10th March 2022. Ambulance staff attended at 01:39 and declared him deceased as a result of a drug overdose. Mr Thompson had last been observed to be alive before 9:30pm on the evening of 9th March 2022, when he was thought to be in a deep sleep, observed by his daughter. Due to the post mortem condition of the deceased upon being found, it is likely that he died on the night of 9th

	March 2022. Mr Thompson's death was probably contributed to by a failure of producing and regularly updating adequate risk assessments in relation to the planning of his section 17 leave and updating them following reported family concerns. In addition, it is possible that Carl's death was contributed to by a failure of both the hospital ward staff and the Community Mental Health Team. The response and lack of escalation following family concerns by ward staff was inadequate. Further to this, it was a failure by the Community Mental Health Team practitioner who assessed Carl via telephone on 9th March 2022. when in fact this should have been carried out face to face.
5	<u>CORONER'S CONCERNS</u> The MATTERS OF CONCERN are as follows. – 1. I am concerned that the jury have found that the risk assesments and risk planning for Carl's s.17 leave in March 2023 was inadequate. This issue was not addressed in the Trusts' internal investigation conducted by [redacted] and I have not received any evidence that there have been reflections or changes following Carl's deathon this issue to reassure me that there is not a continuing risk of future deaths. 2. I am concerned that the Trust's own internal review found that whilst Carl was on leave from the 7th March, the clinical team were made aware of an increase in Carl's risk factors when contacted by his motherwho outlined her concerns. 3. The review concluded that this represented a missed opportunity for the clinical team to understand how several factors may be combining to increase the risk for Carl, including his use of non-prescriptionmedication and illicit substance misuse. 4. The Trust's own review concluded that the clinical team could have sought to understand these risk factors through direct contact with Carl. 5. The Trusts own review concluded that following such direct contact, consultation could have been sought with others within a legal framework to ask Carl to return to the ward with support from services or family. The review concluded that the nursing team could have escalated this information via the on-call system for further medical support. 6. The review concluded that a risk to Carl's physical health was present especially in view of research and evidence for substance misusers starting to use again after periods of abstaining. 7. I am concerned that on the 9th March, Carl should have been seen

	face to face by the CMHT, in line with Trust Policy. Instead he only received a telephone call from a duty worker who had never met him. 8. I am concerned that prior to his commencing leave on the 7th March, Carl had not been allocated a CMHT Care Coordinator, despite being an inpatient for over 3 months, since 31st December 2021. 9. [redacted] gave evidence that although the Trust Review had identified a number of missed opportunites, the Trust Action plan, which contained 6 Action points was still "In progess". [redacted] was not able to identify a single action point that had been completed to date.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisastion) 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 11th July 2023. I, the Coroner, may extend this 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 Mr Thompson's Family, 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	**Anna Morris** **HM Assistant Coroner**  **16.05.2023**