REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Chief Executive, Pennine Care NHS Foundation Trust

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 3rd February 2023, an inquest was opened into the death of Drew Howe who was found dead on 19th October 2022 in a Heavy Goods Vehicle parked on the A18 in Lincolnshire, aged 25 years. The investigation concluded with an inquest which I heard on 25th April 2023.

A post mortem examination confirmed that Mr Howe died as a consequence of:

1)a) Suspension by a Ligature around the Neck.

The conclusion of the inquest was one of Suicide.

CIRCUMSTANCES OF THE DEATH

Mr Howe was found dead on 19th October 2022 on the A18 in Lincolnshire having suspended himself by the neck with a ligature in the back of his lorry.

Mr Howe had experienced a dramatic deterioration in his mental health and had sought specialist help on numerous occasions. At the time of his death, Mr Howe was awaiting a further assessment by the Military Veterans Service having been discharged by the Access Team without any diagnosis or treatment plan being in place.

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. –

The Trust's own investigation into events leading to Mr Howe's death did not consider the full extent of his contacts with mental health services, lacked any meaningful degree of critical analysis of events, and omitted to seek to explore fundamental issues such as access to services from the patient's perspective. As a consequence, it is a matter of concern that the Trust has not taken the opportunity to derive all available learning from Mr Howe's death.

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 **10th July 2023**. 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 Mr Howe's next of kin.

I have also sent a copy to the Care Quality Commission and Stockport Metropolitan Borough Council 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: **15th May 2023**

Signature: Chris Morris HM Area Coroner, Manchester South.