REGULATION 28: REPORT TO PREVENT FUTURE DEATHS.

	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 • Mr Alex Chalk KC, MP, Lord Chancellor and Secretary of State for Justice Copied for interest to: • Chief Coroner • Parents of the Deceased • Greater Manchester Mental Health NHS Foundation Trust • Royal College of Psychiatrists
1	**CORONER** I am Mr Zak Golombeck, Area Coroner for Manchester (City) Area
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	**INQUEST** I concluded the inquest into the death of Girmaye Guyo Liban on 17th May 2023 and recorded that he died from: 1a Drowning I returned an Open conclusion following investigations.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased had a long history of mental health illness and substance abuse. Between 4th June 2020 and 15th September 2020 he was detained pursuant to the provisions of Mental Health Act 1983 at Eagleton Ward, Meadowbrook Unit. The Deceased's discharge from Eagleton Ward was authorised via his mother using her Nearest Relative Powers pursuant to the provisions of Mental Health Act 1983, and its associated Code of Practice. The Deceased then returned to the family home. The evidence that I heard at the Inquest was such that the Deceased was still liable to be held under Section 3 Mental Health Act 1983; however, due to the difference in the test being applied for consideration of an application by a Nearest Relative, there

	was no choice but to discharge the Deceased Further evidence alluded to the concerns from clinicians about this power, and although the evidence was that it is seldomly used, it presents an opportunity for patients and families to deviate from the clinical course prescribed by clinicians. There was no consideration for a Community Treatment Order for the Deceased as the provisions of the legislation refer to discharge from detention. The Deceased remained unwell in the community, and on 10th November 2020 he went missing. His body was found in a local reservoir on 26th November 2020. There was insufficient evidence to determine how he came to enter the water.
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 **MATTER OF CONCERN** is as follows: The Nearest Relative Power may (as it did in this case) present an opportunity for a patient and/or their Nearest Relative to apply to the Responsible Clinician for discharge in circumstances when the patient remains liable for their continued detention There does not appear to be a thorough procedure or legal test for clinicians to apply, and thus there is a risk that Responsible Clinicians may be faced with circumstances whereby a patient will be discharged from hospital despite them continuing to meet the criteria for detention.
6	**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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **Friday 11th August 2023**, 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 Interested Persons. I have also sent it to organisations 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	**DATE:** **NAME OF CORONER:** **Friday 16th June 2023** **Zak Golombeck** HM Area Coroner for Manchester City Area **Signed:**