	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive, Greater Manchester Mental Health NHS Foundation Trust, Trust Headquarters, Bury New Road, Prestwich, M25 3BL.
1	**CORONER** I am Alan Peter Walsh, HM Area Coroner for the Coroner Area of Manchester West.
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 the 5th of December 2022 I commenced an Investigation into the death of Shaun Daniel Houghton, 35 years, born 5th of October 1987. The Investigation concluded at the end of the Inquest on the 26th of May 2023. The Medical Cause of Death was: - 1a Hanging The Conclusion of the Investigation was Shaun Daniel Houghton died as a consequence of self-suspension by Ligature but his intentions at the time remain unclear.
4	**CIRCUMSTANCES OF THE DEATH** 1. Shaun Daniel Houghton (hereinafter referred to as the "Deceased") was found dead in a rural area near Dukes Barn Farm, Hall Lane, Winstanley, Wigan on the 1st of December 2022. 2. The Deceased suffered with diagnosed Emotionally Unstable Personality Disorder, Attention Deficit Hyperactive Disorder, Anxiety and Depression and Mental Health & Behaviour Disorder due to substance misuse.

3. On the 16th of November 2022 the Deceased was admitted to the Prospect Unit at Atherleigh Park Hospital, Atherleigh Way, Leigh, as a voluntary patient after his Partner contacted the Mental Health Crisis Team due to family concerns about his mental health and he received in patient treatment until he was discharged from the Hospital after a Multi-Disciplinary Team meeting on the 25th of November 2022.

4. On the 28th of November 2022 a Senior Nurse Practitioner from Greater Manchester Mental Health Trust visited the Deceased at his home address, and he demonstrated overwhelming feelings of anxiety and low mood. He indicated that he felt that he was impulsively going to end his life. Impulsivity is a recognised symptom of Attention Deficit Hyperactive Disorder and the Deceased continued to express thoughts, plans and intent to end his life. The Senior Nurse Practitioner arranged for the Deceased to be readmitted to the Sovereign Unit at Atherleigh Park Hospital as a voluntary patient later the same day.

5. On the 29th of November 2022 the Deceased was seen by an Associate Specialist Doctor in Psychiatry at the Hospital and a plan was created whereby the Deceased would remain in the Hospital as a voluntary patient with appropriate medication and he would be further reviewed in a Multi-Disciplinary Meeting the following week.

6. On the 30th of November 2022 the Deceased indicated that he wished to take his self-discharge from the Hospital, which was against medical advice, and he stated that he was unhappy with the Sovereign Unit at the Hospital, referring to the lack of Television remote controls on the Unit and he wanted to be moved to the Prospect Unit at the Hospital but a bed in the Prospect Unit was not available at the time.

7. The Deceased's wish to self-discharge was referred to the Doctor on call and he was seen by a Foundation Year 2 Doctor, a junior Doctor, who had only spent a period of 4 months in Psychiatry as part of his general training as a Doctor. The Doctor followed the training he had been given in relation to self-discharge patients and he conducted an assessment in relation to the capacity of the Deceased and a risk assessment in relation to the Deceased but he did not consult or refer the self-discharge to the Senior Doctor who had created the plan of treatment on the previous day or the Consultant, both of whom were in the Hospital at the time. It is unclear from the evidence whether a referral to the Senior Doctor or the Consultant would have changed the decision to allow the Deceased to self-discharge and leave the Hospital or whether a referral would have led

to his detention under the Mental Health Act.

8. The Deceased took his self-discharge from the Sovereign Unit at the Hospital on the 30th of November 2022 and his mother took him from the Hospital to his home address.

9. At 02.34 hours on the 1st of December 2022 the Deceased sent a message and a photograph of himself to his mother [redacted]

10. The Deceased was found in a collapsed and unresponsive condition suspended by a ligature [redacted], where his sister had died in similar circumstances in 2017. His death was verified by a Paramedic from the North West Ambulance Service a short time after he was found.

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. During the Inquest evidence was heard that: -

   i. There are 5 separate units at Atherleigh Park Hospital and the current self-discharge against medical advice procedures or policies are uniform across all 5 units and do not involve a referral to a Consultant or Senior Doctor before the patient leaves the Hospital to check whether the patient should be considered for detention under the Mental health Act 1983.

   ii. There is no check list in relation to self-discharge against medical advice patients for junior Doctors to refer to before the patient leaves the Hospital.

   iii. No medication was prescribed or dispensed to the Deceased at the time of self-discharge.

	2. I request that the Greater Manchester Mental Health NHS Foundation Trust reviews the procedures and policies to cover all 5 units at the Atherleigh Park Hospital in relation to self-discharge against medical advice patients, with a review to there being a written policy, including a check list to assist junior Doctors. 3. I further request that the Trust reviews the procedures and policies in relation a referral to a Consultant or Senior Doctor before a self-discharge against medical advice patient leaves the Hospital to check whether the patient should be considered for detention under the Mental health Act 1983. 4. I further request that the Trust reviews the procedures and policies in relation to the prescription and dispensing of medication before a self-discharge against medical advice patient leaves the Hospital.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe that you 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 the 20th of November 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: - 1. [redacted] Mother 2. [redacted], Partner 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** **25th September 2023**	**Signed** **Professor Dr Alan P Walsh,** **HM Area Coroner,** **Manchester West**