	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 17th of February 2023 I commenced an Investigation into the death of Robert Leigh, 75 years, born 15th of July 1947. The Investigation concluded at the end of the Inquest on the 26th of July 2023. The Medical Cause of Death was: - 1a Hanging The Conclusion of the Investigation was Suicide.
4	**CIRCUMSTANCES OF THE DEATH** 1. Robert Leigh (hereinafter referred to as the "Deceased") was found dead at his home address [redacted] on the 7th of February 2022, having suspended himself by a ligature attached to a loft beam in the roof space at the premises. 2. The Deceased was first referred to the Mental Health Services in in October 2020 with a further referral on the 5th of January 2022, following a deliberate self-harm attempt. He was detained under Section 2 of the Mental Health Act 1983 on the 7th of January 2022, and he was discharged on the 16th of June 2022. He had been treated for depressed mood.

3. Following his discharge, the Deceased was visited regularly by his Community Psychiatric Nurse (hereinafter referred to as the "YL"), and he was able to build a therapeutic relationship with YL, who had been appointed his Care Coordinator. The Deceased and his Partner were able to share their concerns with YL and be supported by the Community Mental Health Team.

4. On the 25th of October 2022 the Deceased was visited by YL, who found the Deceased to be calm and pleasant in mood. The Deceased reported that he was settled in mood and denied any suicidal thoughts or plans. YL arranged to see the Deceased again on the 15th of November 2022.

5. At the time YL was visiting the Deceased every 2 weeks but YL was absent from work between the 10th of November 2022 and the 6th of February 2023 and YL had no contact with the Deceased after the 25th of October 2022.

6. The Deceased lacked a Care Coordinator from the 10th of November 2022 and had no contact with a Care Coordinator after the 25th of October 2022 until a new Care Coordinator was appointed in January 2023 leading to a visit on the 4th of January 2023.

7. During the period from the 25th of October 2022 to the 4th of January 2023 the Deceased had no visits from a Care Coordinator, or a Community Psychiatric Nurse, and all the 2-week planned visits did not take place, so that 4 or 5 visits were missed.

8. Following the absence of YL, a Care Coordinator was not appointed for 2 months and there was no appointment of a Community Psychiatric Nurse to cover the planned 2 weekly visits to the Deceased, which the Deceased and his Partner had found beneficial to his settled mood.

9. Following the 4th of January 2023, the Deceased only had one further visit from a Community Psychiatric Nurse/Care Coordinator prior to his death and there had been no continuity of care after the 25th of October 2022.

10. The Deceased was found dead at his home address [redacted] on the 7th of February 2022, having suspended himself by a ligature [redacted] 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. During the period from the 25th of October 2022 to the 4th of January 2023 there were no visits from a Care Coordinator, or a Community Psychiatric Nurse, and all the 2-week planned visits did not take place, so that 4 or 5 visits were missed. ii. There was no appointment of an interim Care Coordinator or a Community Psychiatric Nurse to cover the 2 weekly planned appointments following the absence of YL. iii. There was no responsibility on a Duty officer to review planned appointments during the absence of a Care Coordinator and to arrange for a Community Psychiatric Nurse to attend any planned appointments. iv. There were no resilience plans in place to cover the absence of a Care Coordinator, either in relation to short term or long-term absences. 2. I request that the Greater Manchester Mental Health NHS Foundation Trust reviews their procedures and policies to cover the absence of a Care Coordinator, both in relation to short term and long-term absences, and in relation to the appointment of an interim Care Coordinator. 3. I further request that the Trust reviews their procedures and policies in relation to the responsibility of a Duty officer to review planned appointments during the absence of a Care Coordinator and to arrange for a Community Psychiatric Nurse to attend any planned appointments. 4. I further request that the Trust reviews the procedures and policies in relation to resilience plans to cover the absence of an appointed Care Coordinator.

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], Son 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**