**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>NHS Cheshire and Merseyside Integrated Care Board 1 Lakeside 920 Centre Park Square **Warrington**, WA1 1QY. |
| 1 | **CORONER**<br><br>I am Marilyn Whittle, assistant coroner, for the coroner area of South Yorkshire (West) sitting in Cheshire Coroners Court |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 18 October 2023 an investigation was commenced into the death of Erik Leigh Marshall, a 17 year old male born in Warrington. The investigation concluded at the end of the inquest on 25 April 2023. The conclusion of the inquest was death by misadventure.<br><br>The medical cause of death was:<br><br>1a. Asphyxiation<br>1b. ligature hanging<br>2 ASD ADHD anxiety.<br>. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Erik Marshall died on 30 September 2023 at his home address [redacted] in Cheshire. He was found suspended by a ligature [redacted]. Prior to this he had suffered from ADHD, mental health issues and had recently received a clinical diagnosis of autism. Erik's sensory needs and mental health presentation meant that he habitually partly drowned himself in the bath [redacted] to experience a buzz and the feeling of numbness in his arms and legs.<br><br>Erik's mental health needs were being treated in the community following an inpatient admission at ancorra house and the Priory. During admission to the Priory Erik was clinically diagnosed with autism. Following discharge from the Priory the plan was to obtain a sensory assessment through OT in the community to help him with the high risk sensory behaviours. The Child Development Centre (CDC), part of Bridgewater Community Healthcare NHS |

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| | Trust, were invited to the CPA meetings and were aware of Erik. Referrals were made to the CDC for an ADOS assessment and OT input in May 2023. The CDC responded to state they did not require an ADOS assessment to provide the support but they did want to review the assessment undertaken at the Priory to see if this complied with NICE guidance before any referral to their nurses was made. They also made a decision, based on the limited information that they had been provided and without speaking to any clinician or family member, that Erik's mental health need was more prominent than the sensory need. The CDC were still waiting for further information regarding the autism assessment in the Priory in August 2023, yet made no attempt to chase this up. I received evidence that escalations were made for specialist input for his sensory needs because it was identified without this it was likely to deteriorate and his risk increase. The OT referral was not accepted because of Erik's age and that whilst he was signposted to adult services these would only assist when he was 18 because there was a commissioning gap. Following escalation to the ICB specific funding was put in place for access to the sensory hive for Erik but the initial appointment only occurred on 22 September 2023 and Erik was found deceased in the back garden of his home 8 days following this. |
| 5 | **CORONER'S CONCERNS**<br><br>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>I was provided with evidence that the OT referral made to the Child Development Centre in Warrington was not accepted because Erik was 17 years old and they were only commissioned to age 16. I was informed that there was no provision in commissioning for new OT referrals for sensory needs and that he was signposted to possible adult services although these would only accept him once he was 18. A gap in the commissioning and support for these high risk individuals was identified. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 20 June 2023. I, the coroner, may extend the period.<br><br>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** |

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| | I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:<br><br>[redacted]<br>Warrington Borough Counsel<br>Bridgewater Community Healthcare NHS Trust.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **25/04/2023 Marilyn Whittle** |