REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1) Pennine Care NHS Trust
1	**CORONER** I am Anna Morris KC, Assistant Coroner for the Coroner Area of Greater Manchester South.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 30th August 2023, I commenced an investigation into the death of David Paul Power. I heard an inquest into his death commencing on the 10th September 2024. I returned my conclusions on the 12th September 2024.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was 28 years old at the time of his death. He lived at home with his family. He had struggled with mixed anxiety and depression for a prolonged period since the death of this parents when he was a child. In September 2022, the deceased made a serious attempt to take his own life by hanging. He was seen at A&E and referred to the Home Treatment Team. The Home Treatment Team referred him to a service to receive psychological/ talking therapies. He was not accepted for by this service (then called Healthy Minds) because they had a policy that they would not accept referrals for indivduals who they did not consider to be sufficiently stable. One of the criteria for stability was that the individual should not have attempted suicide or serious self-harm for 3 months. This meant that David was not accepted for this service.

	but was referred by them to the Living Well Neighbourhood mental health team also who in turn referred him to a peer support coach, provided by the Big Life Group. He was discharged from peer support coaching on the 24th April following a lack of engagement but requested that he be considered again by a multi-disciplinary team meeting. The Living Well Neighbourhood mental health team also discharged him on the 24th April 2023 without a further multidisciplinary meeting. It is now accepted by the neighbourhood mental health team that he should not have been discharged on that date. On the 9th May 2023 the deceased was sent a letter by the neighbourhood mental health team which stated that they were discharging him, and that they did not provide the psychological services he had requested. This was incorrect. It is likely that the deceased interpreted that letter to mean that he would not be provided with the help he had requested. I found that the impact of this letter contributed to a deterioration in his mental health in the period leading to his death and that the deceased became withdrawn and isolated. The deceased's grandmother discovered the deceased hanging in the early hours of the 7th August 2023. [redacted]. Paramedics attended but pronounced his life to be extinct. Notes found near the deceased indicated a clear intention to end his own life. I found that the deceased intentionally took his own life on the 7th August 2023 following a decline in his mental health which was exacerbated by receiving a letter on the 9th May 2023 discharging him from the neighbourhood mental health team.

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. I am concerned that the Home Treatment Team referred David to a service to receive psychological/ talking therapies. This was then called Healthy Minds. This referral took place when the HTT discharged David as they considered him to be sufficiently 'stable' under their HTT definitions. 2. However, David was not accepted for by Healthy Minds because they had a policy that they would not accept referrals for indivduals who they did not consider to be sufficiently 'stable' under their Healthy Minds policies. 3. One of the criteria for stability was that the individual should not have attempted suicide or serious self-harm for 3 months. This was not known to the HTT at the time they made the referral. The effect of this policy meant that David was not accepted for this service, despite him making clear to services that talking therapies was what he needed most to support his mental health. 4. I heard evidence that this policy remains in place within NHS Talking Therapies (the successor to Healthy Minds), but is currently under review. I did not hear any evidence as to if or when it will change. 5. I am concerned that the lack of shared understanding and definition of 'stablilty' for patients along the talking therapies pathway creates a risk of future deaths. 6. I heard evidence that since David's death, the HTT has emailed at the staff at the Tameside HTT to re-iterate the importance of referring cases to SPOE meetings for MDT consideration, and that this has been discussed in two team meetings before February 2024. There was no evidence before me of whether this has been embedded or audited within the team to reduce the risk of future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 13th November2024. 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 namely The Big life Group, [redacted] on behalf of the family. 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 from. 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	**Ms Anna Morris** **HM Assistant Coroner** Signed:  Dated: **18/09/2024**