REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Home Secretary The Secretary of State for Health The College of Policing The Minister for Policing Care Quality Commission Greater Manchester Mental Health NHS Foundation Trust North West Ambulance Service Greater Manchester Police NHS England Trafford Council
1	**CORONER** Christopher Murray HM Assistant Coroner Manchester South Coronial Area Mount Tabor Stockport
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 29th August 2023 an investigation was commenced into the death of Michael Sean Heath aged 35. The investigation concluded at the end of the inquest on 30th September 2024. A jury made a determination that Michael Sean Heath died by taking his own life by [redacted] whilst suffering from an acute episode of a mental health crisis.

4	**CIRCUMSTANCES OF THE DEATH** On 25th August 2023 Michael Sean Heath died in apartment REDACTED Manchester as a result of a fatal [redacted] which penetrated his pericardial sac. He had been suffering with mental health issues for several years. Having considered the evidence, on the balance of probabilities we have identified the following contributing factors – 1) The decision to close the police log on the 25th August 2023 and the police not attending Michael resulted in a missed opportunity for a welfare check, 2) Poor inter agency communication and failures to follow up any outstanding action points, in particular the failure of the Trafford North West Mental Health team to chase up the date when Michael was due to return from Gibraltar and investigate the blank email with Michael's identifier. In addition, the failure of Trafford Council Adult Social Care to verify that police were attending on the 25th August 2023. 3) The failure of mental health services in Gibraltar to notify Trafford Mental Health Team of the exact date of Michael's return to the United Kingdom. This resulted in a lack of mental health support when he returned. 4) The lack of probing by North West Ambulance Service mental health practitioner during telephone triage on 23rd August 2023 resulted in a missed opportunity for a face to face assessment. 5) Michael's mental health condition and his reluctance to take his psychiatric medication consistently and his reluctance to engage with mental health services or General practitioner.

5	**CORONER'S CONCERNS** The evidence heard during the inquest into Michael Sean Heath's death and the findings of the jury confirmed there were a number of factors contributing to Michael's death which are of 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 - In relation to Policing is the extent to which all officers are trained to assess the increasing number of calls to the police which are of a mental health nature, the risks associated with the consequences of not making the right assessment where there may be an immediate risk to life and when to accept that the police are the right agency to be involved in mantal health related enquiries due to their powers of entry; In relation to the management of mental health patients that their carers are made aware of any admission under the Mental Health Act within 24 hours and those patients are supported with access to an independent mental health advocate; The apparent lack of connectivity between mental health services abroad and the UK upon repatriation whilst the patient remains ill; That there is a risk to patients generated by a decision to remove a patient from a GP practice list where the patient resides out of geographical area for that GP practice without considering the wider circumstances and the likely follow on care; and The means of communication is known and agreed between all mental health agencies to ensure all relevant patient information is held in an accessible central repository.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you and/or 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 **27th November 2024**. 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 following [redacted], Michael's father. HHJ Alexia Durran, the Chief Coroner of England & Wales The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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.
9	**DATE** 2nd October 2024 Signed C S Murray HM Assistant Coroner