	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Leeds and Yorkshire Partnership Foundation Trust (Intensive Supportive Service) 2. Leeds Survivor-Led Crisis Service (Leeds OASIS)
1	**CORONER** 1am Leila Benyounes, Assistant Coroner for the coronial area of West Yorkshire (Eastern).
2	**CORONER'S LEGAL POWERS** 1make 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.. http://www.legislation.gov.Uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.Uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 31 January 2025 an investigation was commenced into the death of Christian Barry Marsh. The investigation concluded at the inquest on 16 September 2025. The conclusion of the inquest was: Suicide The medical cause of death was: Ia) Hanging
4	**CIRCUMSTANCES OF THE DEATH** The Deceased, who had a past medical history which included excess alcohol use and recent alcohol withdrawal, was found hanging in a bathroom on 6 January 2025 at the respite facility where had been staying since 3 January 2025 and was pronounced dead at the scene. The Deceased had developed physical and mental health symptoms from alcohol withdrawal and had suffered a worsening of his mental health symptoms in December, which resulted in a psychiatric assessment at hospital and a referral for intensive home based treatment.

	Following an impulsive overdose of [redacted] on 26 December 2024, the Deceased was admitted to hospital on 28 December 2024 and underwent a further psychiatric assessment and was discharged to a respite facility on 3 January 2025, as an alternative to continued hospital admission, under the care of the intensive support service. The Deceased received a visit from the intensive support service on 4 January 2025 and concerns about the Deceased's confusion were raised with the clinical team by staff at the respite facility. No visit took place on 5 January 2025 due to adverse weather conditions, which meant that the 48 hour review did not take place. There is no recorded documentation of any communication between the clinical team and the staff at the respite facility as to the Deceased's presentation or level of risk on 5 and 6 January 2025, and no plan for the 48 hour review to take place on an alternative date. No pre-death communications were discovered, but 1 am satisfied that the Deceased applied a ligature, [redacted] with the intention of ending his life. Death was certified at 12.04 on 6 January 2025 in Leeds.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: There remains no system for formal communication, sharing and handover of information about patients who are admitted to the respite facility operated by Leeds Survivor-Led Crisis Service, but remain under the clinical care of the Intensive Support Service at Leeds and Yorkshire Partnership Foundation Trust. It was candidly accepted in evidence that there needs to be an improvement in communication channels and information sharing for the partnership to run efficiently and effectively and to mitigate risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and 1believe 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, by 11 November 2025. 1, 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** 1 have sent a copy of my report to the Chief Coroner and to the following Interested Persons: the Family of the Deceased. 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 by the Chief Coroner.
9	**LEILA BENYOUNES** **Assistant Coroner for West Yorkshire (Eastern)** **16 September 2025**