

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>The Chief Executive, Greater Manchester Mental Health NHS Foundation Trust</p>
1	<p>CORONER</p> <p>I am Benjamin Myers KC, Assistant Coroner for the coroner area of Greater Manchester South</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On the 9th July 2025, an inquest was opened concerning the death of Mark Alan Hughes, aged 56 years at the time of death. The investigation concluded at the end of the inquest on the 26th February 2026.</p> <p>The medical cause of death was: 1a) Stab wound to the heart</p> <p>The conclusion of the inquest was: Suicide</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Mark Hughes had been diagnosed with anxiety since 2019. During May and June of 2025, his mental state deteriorated significantly. His anxiety heightened, he was unable to sleep and he expressed thoughts of self-harm and suicide. There were occasions when he went missing from home, and on the 13th June 2025, he was found by the police after his wife had reported him missing. Mr Hughes had contact with general practice doctors at the medical centre to which he was registered during this period. On the 20th June 2025, he attended an assessment by the nurse mental health practitioner who worked with the general practice. She considered him to be a high risk of self-harm and suicide. She concluded that an urgent referral to the South Trafford Community Mental Health Team ['CMHT'] was the appropriate course; her intention being that the CMHT would refer Mr Hughes to the Home Based Treatment Team ['HBTT'] who would be able to support him at home, as an alternative to hospital admission. Whilst the purpose of the referral was to obtain support by the HBTT, the referral had to be via the CMHT, because in South Trafford, a general practice is unable to refer direct to the HBTT: it has to be via the CMHT. The nurse mental health practitioner discussed this with Mr Hughes's general practitioner, who agreed with this referral. The general practitioner also prescribed a course of zopiclone to Mr Hughes, in light of the assessment and as advised by the mental health practitioner who conducted it.</p> <p>The CMHT sought to make contact with Mr Hughes on the afternoon of Friday the 20th June 2025. By 17:00 hours that day there had been no contact. The CMHT do not operate during the weekend in the circumstances of a referral such as this. Therefore, the referral was deferred until 09:00 on Monday 23rd June 2025, to be followed-up then.</p> <p>At some time between 21:00 on the 22nd June 2025 and 07:48 on the 23rd June 2025, Mr Hughes locked and barricaded himself inside his garage at his home. Having already taken a potentially fatal quantity of codeine and morphine, he stabbed himself in the chest [REDACTED]. He died as a consequence of the stab wound.</p>

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:

1. The purpose of the referral to South Trafford CMHT by the nurse mental health practitioner on behalf of the general practice, was for Mr Hughes to be referred to the HBTT. This was as a direct alternative to hospital admission.
2. Whilst the usual course is for the South Trafford CMHT to make contact with the service user on the day of referral, the evidence established that on an urgent referral, the South Trafford CMHT have a timeframe of up to 5 days to arrange an assessment.
3. Moreover, with regard to a referral in the circumstances of this matter, the CMHT do not operate over the weekend. This meant that from Friday 20th June 2025 at 17:00, there could be no assessment and no referral to the HBTT, until 09:00 on Monday 23rd June 2025, at the earliest.
4. It was during this period of delay that Mr Hughes took his own life.
5. South Trafford CMHT is part of Greater Manchester Mental Health NHS Foundation Trust. The evidence established that in other boroughs within the area of Greater Manchester Mental Health NHS Foundation Trust, general practice medical professionals are able to refer direct to the HBTT.
6. The After Action Review Report produced by the CMHT after Mr Hughes's death, identified the following as a 'Concern/Gap' : 'To explore whether PCN Nurses can refer directly to HBTT.'
7. In evidence, it was accepted on behalf of the CMHT that there are occasions when a nurse associated with a general practice, or a general practitioner, may need to refer directly to the HBTT; but that the formal procedure does not allow for this.
8. Therefore, at the time of Mr Hughes's death, such a referral could not be made. It still cannot be made, notwithstanding the availability of this course in other boroughs and the findings of the After Action Review.
9. Had it been possible for the nurse who assessed Mr Hughes on behalf of the general practice to refer him direct to the HBTT, the delay occasioned by the system of referral to the HBTT operated by South Trafford CMHT would have been avoided.
10. It was explained in evidence on behalf of the CMHT, that had the HBTT been able to assess Mr Hughes, it was unclear whether they would have accepted the referral. However, what the HBTT would or would not have decided is unknown: nor does this obviate the concern raised.
11. The concern is that in South Trafford, a service user cannot be referred directly to the HBTT from a general practice where:
 - i. there is an urgent referral arising from a high risk of self-harm and / or suicide;
 - ii. where this referral is considered necessary by the general practice professionals; and,
 - iii. where such a referral could be made were it to take place in other boroughs within the area covered by Greater Manchester Mental Health NHS Foundation Trust.

6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you [and / or your organization] have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 29th April 2026. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <ol style="list-style-type: none"> 1. Wife of Mark Alan Hughes, on behalf of the family. 2. Washway Road Medical Centre. <p>I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.</p> <p>I may also send a copy of your response to any other person who I believe may find it useful or of interest.</p> <p>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.</p> <p>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.</p>
9	<p>Date: 4th March 2026</p> <div style="background-color: black; width: 150px; height: 50px; margin: 10px 0;"></div> <p>Benjamin Myers KC HM Assistant Coroner Greater Manchester South</p>