**H.M. Coroner**
**for Wiltshire & Swindon**

**David W.G.Ridley**
*Senior Coroner*

Wiltshire & Swindon Coroner's Court
26 Endless Street
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My ref: DR.A.1114.12

The Chief Executive
NHS England
PO Box 16738
REDDITCH
B97 9PT

Dear Sir

**REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**
**RE: INQUEST TOUCHING UPON THE DEATH OF DAVID DOUGLAS HACKMAN**

I am the Senior Coroner for the above Coroner Area.

I make this report under paragraph 7, schedule 5, of the Coroners & Justice Act 2009 and Regulations 28 & 29 of Coroners (Investigations) Regulations 2013.

On the 10 September 2013 I concluded the Inquest into the death of David Hackman who was born on the 11 November 1937. I determined that the cause of death was that David died from multiple traumatic injuries as a result from a fall from a height. My conclusion as recorded on the Record of Inquest was that David Hackman took his own life.

The circumstances of his death were that David had got into financial difficulties. He had no history of depression but on the 23 June 2013 he took up to 32 paracetamol tablets at his home address before alerting the emergency services and in particular the ambulance service. They arrived at about 1700 hours the same day and took David to the Accident & Emergency Department at the Great Western Hospital in Swindon. Attending medical personnel undertook and internal assessment that triggered contact being made with the supplier of mental health services, The Avon & Wiltshire Mental Health Partnership, and a

mental health assessment was undertaken early evening the following day, Sunday 24 June 2012. Earlier that Sunday morning David had made a couple of attempts to walk off and outside the Ambulatory Care Unit before being guided back to the observation unit by a Staff Nurse. David fully cooperated during the mental health assessment and was not found to be suffering from any mental illness and presented no continuing suicidal ideation. At approximately 11.35 the following day David got dressed and walked out of the Ambulatory Care Unit unnoticed before boarding a bus at 11.40 that took him into the centre of Swindon. He got off the bus, climbed to a 3rd storey on a nearby multi storey car park before jumping off the multi storey car park to his death at approximately 12.15 the same day.

During the course of the Inquest I was satisfied that at the relevant time up to the point he left the unit following David's mental health assessment, that he did not present a real and immediate risk that he would take his own life. Whilst there was a possible risk, I did not determine that it amounted to a significant and substantial risk based on his presentation to the mental health practitioners and GWH staff. Following this tragic event the Great Western Hospital and Avon & Wiltshire Mental Health Partnership have worked together and in particular the Great Western Hospital very soon after this incident installed a card system in the observation unit making it impossible or at least very hard for patients to leave without one of the nursing staff or other medical practitioner using their Keri card to release the door mechanism. Various other changes have been introduced in an attempt to minimise future risk to patients.

At the end of the Inquest I heard evidence as regards the concordance of voluntary arrangements that were established in 2004 and as regards the national reporting and learning service but I am concerned here as regards how this specific incident and in particular its lessons are being disseminated to the wider health care community in England & Wales and in particular other Trusts. I understand the general principle but I would be grateful if you could please specifically explain relevant to this particular incident and the learning exercise that's been carried out as to how the lessons learned have been communicated and if they have not been communicated to review as to why no action is being taken in that respect with a view to the prevention of future deaths.

You are under a duty to respond to this report within 56 days of the date of this report, namely by 5 November 2013, however, if you require an extension to that period then you will need to make a timely request in writing to me. Your response must contain details of the actions taken or proposed to be taken, setting out the timetable for action. If no action is to be taken then you must explain why no action is proposed.

I have sent copies of my report to the Chief Coroner and to the following interested persons:-

[redacted] – Executor
Bevan Brittan, Solicitors representing The Great Western Hospital
Avon & Wiltshire Mental Health Partnership (Caroline Saunders).

I have also copied this report to the The Rt. Hon. Jeremy Hunt – Secretary of State for Health and the Care Quality Commission. 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 form. He may send a copy of this report to any person who he believes may find it useful or

interest. You may make representation to me, the Coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.

Yours sincerely

David Ridley
**Senior Coroner**

Copy to: The Chief Coroner
[redacted] - Executor
Bevan Brittan
Avon & Wiltshire Mental Health Partnership
The Rt. Hon. Jeremy Hunt – Secretary of State for Health
Care Quality Commission