REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Drs [redacted] (King Street Medical Centre, Dukinfield, Cheshire)**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of Manchester South
2	**CORONER'S LEGAL POWERS** 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.
3	**INVESTIGATION and INQUEST** On 10th May 2013 I commenced an investigation into the death of Jonathan Alan Thorpe (dob 25th September 1985). The investigation concluded at the end of the inquest on 6th January 2014. The conclusion of the inquest was that the deceased took his own life. The medical cause of death was 1a Asphyxia secondary to Hanging.
4	**CIRCUMSTANCES OF THE DEATH** Following deteriorating family issues and whilst using various illicit drugs, the deceased went to a tree in a local cemetery and hanged himself from one of the tree branches.
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. – The deceased registered with your GP practice on the 20th March 2013, was seen by [redacted] on the 25th March and was issued a 'sick note' and was prescribed Amitriptyline for depression (despite being a known self-harmer). He was then seen on the 28th March by [redacted] when a further 'sick note' was issued, this time back dated for one month. On neither of these consultations was there any reference to Mental Health Services, either for advice as to his previous involvement with them nor as to whether he needed further input from them.
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 by 4th March 2014. 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 [redacted] (grandmother of the deceased). I have also sent it to Chief Executive Pennine Care NHS Foundation Trust (by his solicitor [redacted]) who may find it useful or of interest. 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 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	**7th January 2014** **John Pollard** **HM Senior Coroner**