	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Dr Matthew Patrick, Chief Executive, South London and Maudsley Trust, Bethlem Royal Hospital, Monks Orchard Road, Beckenham BR3 3BX**
1	**CORONER** I am Dr Andrew Harris, Senior Coroner, London Inner 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	**INQUEST** On 19th October 2012, I opened an inquest into the death of: **Gary Richards, aged 39, died 16th October 2012, Case Ref: 2515-12.** I concluded the inquest at a full hearing on 15th April 2014. The court found that he had committed suicide.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances were recorded as: *Mr Gary Richards had a long forensic history which put him at a very much higher risk of taking his own life. His marriage broke down in April 2012 after which he was homeless and admitted to hospital with suicidal ideation in May. After that time his various mental health assessments did not find any mental illness, but there was a lack of utilization of risk assessment tools. There was no identification of intention of suicide involving trains. He was offered accommodation and help by friends and agencies, including on the last day of his life, but he declined these, having written letters indicating his intention to take his life. On 10th October he deliberately jumped in front of a moving train at Ladywell Station and suffered multiple injuries, dying at KCH at 18.00 on 16th October 2012.*
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. – (1) Psychiatric staff did not properly assess his risk of self harm, nor communicate his vulnerability to others. At discharge on 10/05 his risk of self harm was not fully measured. On being seen on 14/06 his risk assessment was not recorded and the risk plan not sent to the GP. The consultant explained that the risk was not mitigatable as no mental illness was found. Evidence was heard that his forensic history indicated that he belonged to a group of patients with 80 times the risk of suicide compared with the general population, yet he was considered at low risk. The value of performing a proper risk assessment to demonstrate the risks and vulnerabilities of the patient to other agencies, such as housing and social services, does not seem to have been considered, although it was reluctantly conceded by the consultant to be of value especially as homelessness presented as the primary problem. (2) After discharge in May, he was not followed up, as there was no address and his mobile phone number was not recorded. After attendance in June, again there was a

	mobile phone number was not recorded. After attendance in June, again there was a failure to contact him for follow up, reported to be due to a phone failure. The failure to ensure reliable communication pathways for follow up is a potential risk for vulnerable patients. (3) The Serious Untoward Incident Report (Acute Mental Health Comprehensive Level Two Report, 10th October 2012) found seven areas of concern and service delivery problems, including weaknesses in risk assessment and recognition of suicide plan, lack of clarity of responsibility for risk assessment, inadequate 7 day follow up and communications with GP and problems in support as no mental illness. A plan was adopted which required review of clinical pathway focusing on risk assessment, staff induction and a review of homeless services and interagency working. Despite the intervening eighteen months, progress on these was not evident and it was clear that these actions had not been completed.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the Trust has 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 Friday 4th of July. 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. If you require any further information or assistance about the case, please contact the case officer, [redacted]
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted] (father), Chief Eagle Three Feathers. I have also sent it to the Department of Health, 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	**[DATE]** 9th May 2014 **[SIGNED BY CORONER]**