**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

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

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. British Transport Police**<br>**2. Royal Berkshire NHS Foundation Trust**<br>**3. Berkshire Healthcare NHS Foundation Trust.**<br>**4. Inspector [redacted] – Thames Valley Police (author of the "Interagency joint Working Protocol for the Management of Mental Health Thames Valley Area"** |
| 1 | **CORONER**<br><br>I am Ravi Sidhu, assistant coroner, for the coroner area of Berkshire |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 13th of May 2011 I commenced an investigation into the death of Stephen Peter Church. The investigation concluded at the end of the inquest on 1st of July 2014. The conclusion of the inquest was a Narrative as attached. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Stephen Church was found dead at the entrance to the multi-storey car park at the Royal Berkshire Hospital on the 13th of May 2011. He had actively sought to take his own life that morning and having been detained by British Transport Police officers under section 136 of the Mental Health Act 1983. He managed to abscond and take his life. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) The chain of command within the British Transport Police was broken unacceptably leading to only one police officer responsible for detaining Mr Church.<br>(2) There was insufficient knowledge and understanding amongst members of the psychiatric liaison service and the Royal Berkshire Hospital as regards the "Interagency joint Working Protocol for the Management of Mental Health Thames Valley Area"<br>(3) There was a lack of joint working amongst the British Transport Police, Royal Berkshire Hospital and psychiatric liaison service staff members to ensure that Stephen Church was safe and the high risk of him self-harming addressed promptly.<br>There was a lack of appreciation amongst the psychiatric liaison service, Royal Berkshire Hospital staff and British Transport Police as to the importance of contacting an approved mental health professional promptly to arrange a Mental Health Act assessment. |

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| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by Wednesday 27 August 2014. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the interested persons referred to at the beginning of this Regulation 28 Report.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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. |
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