REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] East London NHS Foundation Trust** **2. Hackney Alcohol Recovery Centre** **3. Family Mosaic** **4. [redacted]**
1	**CORONER** I am Gail Elliman, assistant coroner, for the coroner area of Inner North London
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 24 June 2013 I commenced an investigation into the death of Graham Darby, born on 18 July 1956. The investigation concluded at the end of the inquest on 31 October 2013. The conclusion of the inquest was that the medical cause of death was suspension by ligature and that his death was a suicide.
4	**CIRCUMSTANCES OF THE DEATH** I concluded that Graham Darby had a mental and behavioural disorder due to alcohol dependence and that the day after having been evicted from his home he was found dead at his home address having forcibly re-entered the property.
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. – That there were a number of agencies involved in both trying to assist Mr Darby and to deal with his anti-social behaviour (which led to the eviction). That although information was passed on generally between agencies and that communication was ongoing about Mr Darby, the evidence disclosed that one significant piece of information was not flagged up as it was not made sufficiently clear to Family Mosaic who were responsible for his housing and eviction. This was that the psychiatrist from ARC made a specific observation that Mr Darby had said that he had a knife and a rope in his property and would take his own life if evicted. The witness from Family Mosaic said that this particular piece of information was not passed on and that if it had been different actions may have been taken. Such direct threats should be flagged up in similar circumstances.
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe your organisation 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 Thursday 18 September 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: [redacted] East London NHS Trust, [redacted] (brother of deceased), Family Mosaic, Hackney ARC 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	**24 July 2014** **E. G. Elliman, Assistant Coroner**