REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Sheffield Health & Social Care Trust** [redacted]
1	**CORONER** Christopher Peter Dorries, senior coroner for the coroner area of South Yorkshire (West)
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 19 December 2013 I commenced an investigation into the death of Alexander Matthew Holt (aged 30). The investigation concluded at the end of the inquest on 19 September 2014. The conclusion of the inquest was that Mr Holt took his own life, asphyxiating himself by a ligature in his accommodation at Beaufort Rd, Sheffield on 16/17 December 2013.
4	**CIRCUMSTANCES OF THE DEATH** Mr Holt was well known to the Health & Social Care Trust. He had a history of attempts at self-harm, some of which were very serious events. His parents had expressed clear and sensible views as to the form of treatment that would most likely be beneficial for their son. In particular, it had previously been intended by his then consultant that there would be assertive community support which never took place. His parents described their son as 'losing hope' at the lack of meaningful program available. A short period before his death Mr Holt took an overdose of medication but this was not communicated to those supervising the accommodation where he was staying. Mr Holt lost his life by an act that was impulsive but deliberate.
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) The prospect that Mr Holt was minimising or concealing the true extent of his suicidal intent should have been subject to a greater degree of challenge and his parent's fears in this regard should have carried more weight (2) It was accepted at the inquest that there was a failure to provide the type of treatment originally intended. (3) The referral process for SORT failed to materialise despite repeated concerns expressed. (4) Importantly, Mr Holt's parents described how too many people became involved in his care over a period preventing the necessary degree of continuity. (5) There was a failure to maintain a good flow of information. Most strikingly, the staff

	at Beaufort Road were not advised of Mr Holt's most recent attempt at self-harm (by overdose of his medication) and were thus unaware of the degree of risk when he returned to that address where support would have been available. (6) It was accepted at the inquest that more could have been taken into account in risk assessing Mr Holt.
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 31st March 2015. I 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 [redacted] I have also sent a copy to the Care Quality Commission 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	**3rd February 2015** **CP Dorries**