ANNEX A

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. Worcestershire Health and Care NHS Trust** **2.** **3.**
1	**CORONER** I am Geraint Urias Williams, Senior Coroner, for the coroner area of Worcestershire
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 28th April 2014 I commenced an investigation into the death of Jonathan James LANDER then aged 37 years. The investigation concluded at the end of the inquest on 18 March 2016. The conclusion of the inquest was narrative formulation (copy herewith) the medical cause of death being 1(a) multiple trauma, 2 intoxication by drugs of abuse .
4	**CIRCUMSTANCES OF THE DEATH** On 28th April 2015 Mr Lander was killed when he was struck by a train on the tracks near to Black Bridge, Worcester Road, Hartlebury.
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) That there is not in place any policy or procedure for the following up of individuals who are seen by one service and thereafter discharged to another service. In the course of the inquest I was provided with a Root Cause Analysis which identified the failing mentioned above and which contained an action plan indicating that such a policy/procedure was to be implemented by September 2015. I was told in the course of the inquest that that policy/procedure has not been implemented. I was left with the sense that this is still to be considered but there appears to be no sense of urgency. I was further told that the Trust has a governance procedure to ensure that action plans are "followed through" but it seems to be clearly the case that this has not worked either.

	I respectfully suggest that you consider urgently the necessity for a such a procedure / policy and to implement it. (2) (3)
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 16th May 2016 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, Next of Kin. I have also sent it to Swanswell 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	**Signed** **G U Williams** **18th day of March 2016** **H M Senior Coroner**