Mark Andrew Beresford
Assistant Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Ms Kathryn Singh, Chief Executive** Rotherham Doncaster and South Humber NHS Foundation Trust, Trust Headquarters Woodfield House, Tickhill Road, Doncaster, DN4 8QN
1	**CORONER** I am Mark Andrew Beresford, Assistant Coroner for South Yorkshire (East District)
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 25th September 2015 I commenced an investigation into the death of Jason Derek Vaughan, 43. The investigation concluded at the end of the inquest on the 4th March 2016. The conclusion of the inquest was Suicide. The medical cause of death was hanging by the neck.
4	**CIRCUMSTANCES OF THE DEATH** 1. Jason lived with his wife and young daughter at [redacted] 2. He had no history of suicide attempts but did suffer from anxiety and depression, which developed, in 2009, as a result of uncertainty over his employment, and which continued until the date of his death. 3. Jason sought assistance from his general practitioner and was also under the care of the local Improving Access to Psychological Therapies (IAPT) service. 4. Jason committed suicide, by hanging himself by the neck, at his home address, on 23rd September 2015. 5. An investigation into the Serious Incident (Ref. 2015/31212) was carried out by [redacted] who gave evidence at the inquest.
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 effectiveness of the IAPT electronic patient clinical records system (SystemOne) may be limited, in some instances, by there being inserted insufficient written narrative detail (eg. As to medication commencement dates, doses, changes etc.) to accompany the coded data entries in the drop down box selection (2) The existing IAPT risk assessment tool utilises a numerical rating system which has, as its starting level 1, "things feel so bad that you think about killing yourself", and which does not allow for the recording of a less threatening position, thereby not providing a means of reflecting a deterioration, is a patient's state of risk, over time, to the current Level 1 status. (3) It may not be universally recognised by all mental health practitioners, that the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2015)

	has identified an increasing number of suicides amongst middle aged males and also socio-economic factors becoming increasingly common in suicides.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Ms Kathryn Singh, Chief Executive, Rotherham, Doncaster and South Humber NHS Foundation Trust 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 **Friday 29 April 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 [redacted] 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	Dated 11 March 2016 Signature_____ Assistant Coroner for South Yorkshire (East District)

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