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:** [redacted], **Director, Adults and Community Wellbeing,** **North Lincolnshire Council,** **Ashby Road,** **Scunthorpe DN16 1AB**
1	**CORONER** Paul Kelly, Senior Coroner for the area of North Lincolnshire and Grimsby
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 2nd June 2016 I began an investigation into the death of Terry Stapleton Latimer who died on 27th May 2016 by hanging. The investigation concluded with an inquest on 25th May 2017
4	**CIRCUMSTANCES OF THE DEATH** On 27th May 2016 the deceased was found dead by hanging at his home address. An inquest determined he died by suicide. The deceased received inpatient care in local psychiatric services between 18th April and 25th April 2016. On 15th May 2016 Police persuaded him to attend A&E at Scunthorpe General Hospital following safety concerns. The deceased did not wait to be seen. A Safeguarding notification was generated by the attending Police Officer and submitted through usual procedures on 16th May 2016.
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. – The safeguarding notice was not acted upon either at all or appropriately. In particular a request accompanying the notice that the case be referred to Mental Health Services was not complied with. Evidence indicates lack of clarity in understanding whether the notice is just for information or should be followed up.
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. Namely a review with stakeholders (Police, A&E, mental health services) as to practices and procedures for safeguarding referral of mentally disordered persons known to be a threat to his or her own safety.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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 the following Interested persons, namely the deceased's family. 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 1st June 2016** **H.M. Senior Coroner.**