for Bedfordshire and Luton

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **The Chief Executive** East London NHS Foundation Trust Corporate Headquarters 9 Alie Street London. E1 8DE
1	**CORONER** I am IAN PEARS, Acting Senior Coroner, for the coroner Area of Bedfordshire & Luton
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 5th December 2016 I commenced an Investigation into the death of ANDREW STUART **CODLING** aged 39. The investigation concluded at the end of the Inquest on 1st June 2017. The Conclusion of the Inquest was 'SUICIDE'. The medical cause of death was: I(a) Hanging
4	**CIRCUMSTANCES OF THE DEATH** On the 26th November 2016 the Deceased was found hanging at Old Warden Tunnel Woods near Cardington, Bedfordshire. He had had one previous suicide attempt and was under the care of the Biggleswade Community Health Team at the time of his death.
5	**CORONER'S CONCERNS**

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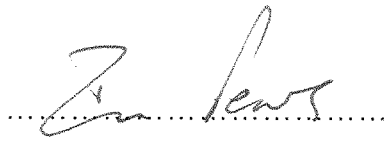
	During the course of the Inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (1) The last call from the Community Health Team to the deceased's mobile went to voice mail. It reportedly said "...it is 3.57pm [Friday] now and I am leaving the office at 4.00pm. You have literally 3 minutes to call me, otherwise , call me Monday if you still need something". (2) That call was in response to a call by the deceased. (3) That call missed the opportunity to re-inforce the fact that there were other means of help should the deceased require it, including the crisis numbers already provided by the Service. (4) Reminding the deceased that there was provision to provide support before Monday morning may have been all the deceased required to avoid taking the decision to hang himself particularly, bearing in mind it was the deceased who had initiated the call
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe East London 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 **7th August 2017**. 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: **Paula Codling**. 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 23rd June 2017  IAN PEARS Acting Senior Coroner Bedfordshire & Luton

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