	REGULATION 28 REPORT ON ACTION TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **St Lukes Primary Care Centre** **Timken Way South** **Duston** **Northampton** **NN5 6FR**
1	**CORONER** I am Anne Mary Christine Pember, Senior Coroner for the coroner area of Northampton.
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 28/03/2017 I commenced an investigation into the death of William John Callis whose date of birth was 19/02/1954. The investigation concluded at the end of the inquest on 07/03/2018. The medical cause of death was:- 1a) Hanging
4	**CIRCUMSTANCES OF THE DEATH** William John Callis was suffering from depression and sought help from his GP surgery in this regard. [redacted] made an urgent referral to the Crisis Team on 10/02/2017 and he was seen that afternoon. He was later reviewed by the Mental Health team. He later was discharged from the urgent care and assessment team on 20/02/2017. On 14/03/2017 he was seen by Advanced Nurse Practitioner [redacted] at the GP surgery. His depression and anxiety symptoms were raised so [redacted] referred him back to the Mental Health Team. This referral was not taken on. William John Callis later hung himself at his home address on 28/03/2017.
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 could 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) During the inquest it became clear that there was no specific instruction as to

	the correct procedure for a GP practice to adopt when making a referral to the Urgent Care and Assessment team.
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 7th June 2018. 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] **- represented by Lime Personal Injury** [redacted] **- Assistant Director of Mental Health, Speciality Services & Learning Disability, Northamptonshire NHS Foundation Trust** **All GP Surgeries in Northamptonshire** Similarly, you are 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.
9	**[DATE]** **12th April 2018** **[SIGNED BY CORONER]** A. M. Pemberton