REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Sir David Dalton** **Chief Executive** **The Penine Acute Hospitals NHS Trust** **Whitehall Street** **Rochdale** **OL12 0NB** 2. **Claire Molloy** **Chief Executive** **Rochdale Community Mental Health Team** **c/o Pennine Care HNS Foundation Trust HQ** **225 Old Street** **Ashton-Under-Lyne** **Lancashire OL6 7SR**
1	**CORONER** I am Russell Caller for the coroner area of Inner West London
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** **In July 2017 I opened an investigation into the death of Paul Robert Allan. The investigation concluded at the end of the Inquest on Tuesday 19th June 2018. The medical cause of death was 1a. Multiple Injuries and the short-form conclusion was suicide.**
4	CIRCUMSTANCES OF THE DEATH On the evening of 16th July 2017 Paul Robert Allan walked into the tunnel and on to the track at platform 1 West Central Line at Oxford Circus tube station and Paul Robert Allan was struck by a train that was travelling from Tottenham Court Road to Oxford Circus Westbound.
5	**Coroners Concerns:** The **MATTERS OF CONCERN** are as follows: – 1) The Rochdale Community Mental Health Team discharged Paul Robert Allan from their care instead of transferring him to the Community Mental Health Team in Stoke where Paul Robert Allen was moving to.

	2) The Rochdale community Mental Health Team failed to consult or work with the Drug and Alcohol advisory services in relation to Paul Robert Allan as it is required to do.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation 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 27th September 2018, 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 person: 1. [redacted] 2. [redacted] Hill Dickinson LLP (representing Pennine Acute Hospitals NHS Trust- email supplied) 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.
	25th July 2018  **Russell Caller** **HM Assistant Coroner,** **Inner West London,** **Westminster Coroner's Court,** **65, Horseferry Road,** **London.** **SW1P 2ED.**