Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 **Bohdan Solomka Medical Director Norfolk and Suffolk NHS Foundation Trust**
2 **Chief Coroner**

1 CORONER

I am Daniel SHARPSTONE, Assistant Coroner for the area of Suffolk

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 20/03/2018 I commenced an investigation into the death of Anthony Hayward BUCKINGHAM aged 33. The investigation concluded at the end of the inquest on 01/04/2019 13:20. The conclusion of the inquest was:

1a Compression of neck structures

1b

1c

Conclusion – Narrative
Took his own life on the background of deficiencies in mental health care and support

4 CIRCUMSTANCES OF THE DEATH

Died 13/03/2018 at home 10 Hazel Close Rendlesham Woodbridge Suffolk. Metal cable around neck. Suicide note left. Tony Buckingham attempted suicide on 3rd February 2018 after splitting from girlfriend and two children. He had left a six page suicide note.
Following this suicide attempt Mr Buckingham stated in the following month that he had constant suicidal thoughts, his mood was down to 2/10 , had a degree of hopelessness not previously recorded and he felt like he did just before his suicide attempt. The mental health team were visiting alternate days.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows: (brief summary of matters of concern)
At the Inquest it was highlighted the following could have been done to try and prevent his death
1/ Daily visits from the mental health team
2/ Involvement of the next of kin (his father)
3/ Formal mental health act assessment
4/ Involvement of the practice nurse
5/ Use of Corner house care facility

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 June 03, 2019. 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
Family
and to the Local Safeguarding Board (where the deceased was 18). I have also sent it to
……
who may find it useful or of interest.

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

Daniel SHARPSTONE
Assistant Coroner for
Suffolk
Dated: 09/04/2019