REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Secretary of State for Health
1	CORONER I am Alison Mutch, Senior Coroner, for the coroner area of South Manchester
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 3rd July 2018, I commenced an investigation into the death of Danyon Robert Chesters. The investigation concluded on the 28th January 2019 and the conclusion was one of suicide. The medical cause of death was **1a) Decapitation**
4	On 2nd July 2018 Danyon Robert Chesters went onto the railway line under Trafford Bridge Road and was struck by a train. Post-mortem toxicology found significantly excessive quantities of bupropion within his system. There were no suspicious circumstances and no evidence of third party involvement in his death.
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 inquest heard that : 1. Mr Chesters had previously sought help for Mental Health issues and had found significant delays in accessing services. Subsequently he had lived and worked in Germany. Whilst there he had been treated by German Mental Health Services. Following his return to England, he required further treatment. He saw his GP who indicated that there were significant delays in accessing Mental Health Services via the NHS. He felt this reflected his previous experiences with the NHS and that he could not wait and went to a private therapist. This expense caused him additional worry and he saw his therapist less regularly than would have been seen as the optimum frequency consequently. As a result of seeing a private therapist there was no joined up care in relation to his mental health and no information sharing between professionals involved in his care. 2. The private therapist did not make further enquiries and did not show any curiosity about how he was being prescribed medication for his mental health condition. Private therapists do not appear to have any obligation to obtain information about prescribing of medication for mental health conditions or how that may impact the provision of therapy.
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 23rd April 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 namely [redacted], husband of the deceased, and Mr Chesters' parents, 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	**Alison Mutch OBE** **HM Senior Coroner** **26.02.2019**