REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Rt Hon Matt Hancock MP, Secretary of State for Health
1	**CORONER** I am Professor John S Pollard H M Assistant Coroner, for the Coroner Area of Manchester West
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 18th January 2019 I commenced an investigation into the death of Rebecca Louise Henry, Date of Birth 22.10.1991. The investigation concluded at the end of the inquest on 17th July 2019. The conclusion of the inquest was suicide from multiple injuries following her standing in the path of an oncoming train.
4	**CIRCUMSTANCES OF THE DEATH** On the 13th January 2019 she presented to hospital having attempted to kill herself. She was a voluntary patient in Oak Ward, Bolton, overnight and was assessed by muti disciplinary team who said she was not detainable and she was discharged. Later that same day she stood in front of an on-coming train at Farnworth Train Station.
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: During almost 40 years sitting as a Coroner, Senior Coroner and now Assistant Coroner, I have heard numerous inquests where had there been communication between the doctors, nurses and therapists caring for patients with mental health issues, and the close relatives of those patients, many issues might have been explained and lives saved. The reason given in the present case, as in so many others, is that of patient

	confidentiality. Whilst the medical authorities are usually right in their interpretation, one wonders whether some form of enquiry/commission might be established to review the law on confidentiality and especially where it interfaces with those patients who have 'capacity' but where their relatives have valuable information which could help doctors decide on best care and treatment.	
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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 26th September 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: [redacted] Mother [redacted] Father I have also sent it to The Law Commission 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	**Dated** **01.08.2019**	**Signed**  **John Stanley Pollard, H M Assistant Coroner**