REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Ms Carolyn Regan, Chief Executive West London Mental Health Trust, Trust Headquarters, 1 Armstrong Way, Southall UB2 4SA.
1	**CORONER** I am Mr Christopher S Murray Assistant Coroner for the Coroner Area of 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	**INQUEST** On 30th October 2018 the Court opened an inquest into the death of Matthew George Kaliniecki WILLIAMSON. He had died on 24th October 2018. **The inquest was concluded on 11th October 2019.** The Record of the Inquest stated the following: The medical cause of death found for Matthew was: 1a Hanging
4	**CIRCUMSTANCES OF THE DEATH** Where, when and how, by what means and in what circumstances did he die: Matthew was found locked in a bathroom at [redacted]. He had hung himself by a dressing gown cord attached to a wall mounted radiator resulting in his death at the scene on 24th October 2018.
5	**CORONER'S CONCERNS** During the course of the inquest, the evidence revealed a matter giving rise to concern that in my opinion means that there is still a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The MATTER OF CONCERN is as follows: There appears to be a lack of opportunity for carers and family members to provide more pertinent information to clinical mental health teams and the interplay between mental health providers isn't clear. This makes it very difficult to navigate as there is no patient road map which would assist with access to and type of treatment.
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. 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 Person: 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	**15th October 2019** **Mr Christopher S Murray Assistant Coroner West London**