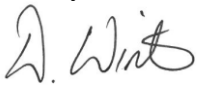




Derek Winter DL
Senior Coroner for the City of Sunderland

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>Chief Executive of Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust</p>
1	<p>CORONER</p> <p>I am Derek Winter DL, Senior Coroner for the City of Sunderland</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/ukxi/2013/1629/part/7/made</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 17th November 2020 I commenced an Investigation into the death of Daniel David Rennoldson (Daniel), who was born on 10th July 1993 and died at ■ Greenfinch Road in Houghton-le-Spring on 11th November 2020 aged 27 years.</p> <p>The Investigation concluded at the end of the Inquest on 16th June 2021. The conclusion of the Inquest was Suicide, the medical cause of death being: -</p> <ul style="list-style-type: none">Ia Pressure on the NeckIb HangingII Ethanol Toxicity
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Daniel died at 33 Greenfinch Road, Houghton le Spring on 11th November 2020 following a recent contact with mental health services.</p> <p>The day before his death Daniel had been referred by the police to the street triage team after he had expressed suicidal intentions. Daniel was signposted back to his GP.</p> <p>At 03:47am on 11th November 2020 Daniel made a telephone contact with the initial response team for 24 minutes. A face to face meeting with the assessment team was thought to be appropriate, but that team were already engaged. Daniel had indicated that he wished to sleep so the meeting was to be deferred. The initial response team finished their shift at 08:00am. At 10:30am the Crisis Clinician attempted to telephone Daniel but had no response, so left a message. Daniel lived within the catchment area of another crisis team, who were contacted at 11:37am. That team attended Daniel's home address at 15:15hrs to learn that Daniel had died and communicated the fact of death to the</p>

	<p>original team at 17:55hrs.</p> <p>Daniel had contacted the police at 04:18am to state that he was going to end his life. The police attended his home address at 04:28am to discover that Daniel had died.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows: –</p> <p>Although the Trust had produced an Action Plan dealing with certain matters, in view of the evidence at the hearing the adequacy of the Action Plan should be reviewed together with the additional concerns, which emerged, namely:</p> <ol style="list-style-type: none"> 1) there appeared to be no contingency to deal with more than one face to face response at a time, leaving other callers potentially at risk; 2) almost 12 hours had elapsed from Daniel's call to someone visiting his home address with no mechanism to identify cases, which had not been progressed.
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 12th August 2021. I, the Coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: -</p> <ul style="list-style-type: none"> • Family • Care Quality Commission (CQC) <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>Dated this 17th day of June 2021</p> <p>Signature </p> <p>Senior Coroner for the City of Sunderland</p>