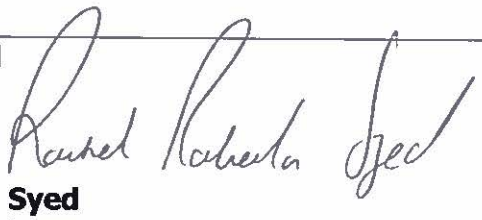
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Chief Executive, North West Boroughs Healthcare NHS Foundation Trust, Hollins Park House, Hollins Lane, Winwick, Warrington, WA2 8WA
1	**CORONER** I am Rachel Syed, HM 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 the 14th October 2019, I commenced an Investigation into the death of Danny James Holt-Scapens, born on the 5th March 1996. The Investigation concluded at the end of the Inquest on the 18th March 2020. The medical cause of death was: - 1a) Hanging The Inquest conclusion was Suicide.
4	**CIRCUMSTANCES OF THE DEATH** On the 10th October 2019, the deceased was found dead at his home address, having used a rope as a ligature to hang himself. The deceased left goodbye notes expressing his intentions. The deceased suffered from anxiety and depression and was receiving active treatment for these conditions. On the 30th July 2019, the deceased family sought help from the crisis team following concerns for his welfare. The assessing clinician did not create any contemporaneous records of the telephone consultation which took place but it is accepted that the family was informed that as the deceased had capacity to make decisions and did not wish to engage with this service, no interventions could take place. The family were advised to contact the police if they had any welfare concerns. On the 06 September 2019, the deceased saw his General Practitioner, complaining of low mood. During the assessment, he did not make any mention

	of any active thoughts to end his own life. The deceased had contact with the police on the 02nd and 07th October 2019, where no concerns were recorded about any suicidal thoughts. This is disputed by the family and from the evidence heard it is not possible to resolve this factual dispute.
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 the Inquest, evidence was heard that: - i. There should be better interagency working and sharing of key information between agencies who had contact with the deceased in the period leading up to his death. ii. The assessing crisis team clinician who undertook the telephone assessment with the deceased on the 30th July 2019, did not make contemporaneous records or document any decision-making rationale including detailing the capacity assessment undertaken. 1. I request that The Chief Executive of North West Boroughs Healthcare NHS Foundation Trust, reviews its staff training and policies in relation to these matters.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe that 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 **19th May 2020**. 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:- 1. The bereaved family 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** **24th March 2020**	**Signed**  **Rachel Syed** **HM Assistant Coroner**