	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr [redacted], Assistant Chief Constable, Devon & Cornwall Constabulary**
1	**CORONER** I am Andrew Cox, the Acting Senior Coroner for the coroner area of Cornwall and the Isles of Scilly.
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 12 October 2020, I concluded an inquest into the death of Darrell Sharples who died on 21 July 2018, then aged 49. . The medical cause of death was recorded as: 1a) Asphyxia; 1b) Hanging 1c) II) I recorded a Conclusion of Suicide.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances leading up to Mr Sharples death are set out in the attached summing up and judgment.
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. May I please direct your attention to pages 21-23 of the attached summing up. **ViST forms**. These generate a lot of data about potentially vulnerable individuals. I consider deaths may be prevented in the future where that data could be appropriately shared with partner agencies. I have in mind, in particular, Cornwall Partnership Foundation Trust and Kernow Clinical Commissioning Group (on behalf of GPs.) I recognise there is a need to limit or prioritise the data shared so that it is manageable and targeted to the most vulnerable and/or those at greatest risk of harm or self-harm. I further recognise that there may well be legitimate concerns about data protection. I was told this may be overcome where a particular individual consents to the sharing of data. Where someone refuses to consent, however, I accept sharing may be more problematic and legal advice may be required.

	Custody Access to CJLDT Assessments and Consideration of Ramifications of Imposing Bail Conditions on Vulnerable Individuals. At his assessment by CJLDT in May 2018, it had been recognised that [redacted] was a strong protective factor keeping Darrell from harming himself. After his release from custody in July 2018, a bail condition was (correctly) imposed that he was not to contact his wife. This had the unintended consequence of removing that strong protective factor. In the event those in custody had known of the assessment in the CJLDT records, that may have had an influence on assessing Darrell's risk to himself at the point of release. It may have led to a request to an HCP or CPFT to re-assess Darrell's risk to himself. It may be that the standard questions completed by custody sergeants could be amended to require an Officer to review or have reviewed any assessment in CJLDT prior to the imposition of a bail condition on a vulnerable individual and his release from custody.
6	**ACTION SHOULD BE TAKEN** In my opinion 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 23/12/20. 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]. I am also sharing this letter with those who I think may have an interest being Dr [redacted], Joint Interim Medical Director at CPFT and Ms [redacted], Deputy Director of Primary Care in KCCG. While it is a matter for you, it may be that you will feel there would be some value in exploring these issues on a multi-agency basis. 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	**[DATE]** **[SIGNED BY CORONER]** **28/10/20**

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Dr [redacted], Interim Joint Medical Director, Cornwall Partnership Foundation Trust**
1	**CORONER** I am Andrew Cox, the Acting Senior Coroner for the coroner area of Cornwall and the Isles of Scilly.
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 12 October 2020, I concluded an inquest into the death of Darrell Sharples who died on 21 July 2018, then aged 49. . The medical cause of death was recorded as: 1a) Asphyxia; 1b) Hanging 1c) II) I recorded a Conclusion of Suicide.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances leading up to Mr Sharples death are set out in the attached summing up and judgment.
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. At inquest, I heard evidence from a Mr [redacted] who, on behalf of CPFT, conducted a telephone triage assessment of Mr Sharples. I have set out where I felt that assessment was inadequately conducted in the attached judgment. Of particular concern was the fact that Mr [redacted] was, at best, vague about whether he was familiar with the Trust's Operational Policy to which, at Appendix 1, were attached the relevant eligibility criterea. Of further concern was that he was not aware of the Triage guidance the Trust had produced. I made clear my view that any clinician performing that role had to be familiar with both documents. I have been told that the Trust has moved to a 'needs-based' evaluation system and that fresh guidance is being produced to assist those performing triage assessments. You may feel that the Trust needs to be confident that all those performing triage assessments in the future will be familiar with the revised triage guidance and Operational policy and has a robust system in place to ensure this is the case.

6	**ACTION SHOULD BE TAKEN** In my opinion 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 23/12/20. 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.
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9	**[DATE]** **[SIGNED BY CORONER]** **28/10/20**