IAN SINGLETON
Assistant Coroner for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Endless Street Surgery, 72 Endless Street, Salisbury, Wiltshire SP1 3UH** **Department of Health, Richmond House, 79 Whitehall, London SW1A 2NS**
1	**CORONER** I am IAN SINGLETON, Assistant Coroner for Wiltshire and Swindon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 15/01/2016 I commenced an investigation into the death of Miles Benedict Abel, 48 . The investigation concluded at the end of the inquest on 07 July 2016. The conclusion of the inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** On the 14 January 2016 whilst at home at 1 Francis Villas Kingsland Road Salisbury Wiltshire Miles placed a ligature around his neck , attached the other end to a window which caused the injuries which led to his death.
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. – (1)The procedure in place at the time of Miles death where a GP from the surgery wished to refer a patient to the Community Mental Health Team was to fax the request but no audit trail was kept to show the fax had been sent. (2) Although a telephone call was supposed to be made by the surgery to check that the fax had been received this was not always followed. (3) Hence if for any reason the fax was not sent and the follow up telephone call was not made the Community Mental health Team would be unaware of the fact a patient had been referred to them.

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 26 September 2016. 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 have also sent it to Avon and Wiltshire Mental Health Partnership NHS Trust, Jenner House, Langley Park, Chippenham SN15 1GG 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 29 July 2016 Signature For Ian Singleton Assistant Coroner for Wiltshire and Swindon

CORONER FOR WILTSHIRE AND SWINDON

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