John Broadbridge
Assistant Coroner for Western Area of North Yorkshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Amanda Bloor, Chief Executive, Harrogate and Rural District Clinical Commissioning Group [redacted]** **2. HHJ Lucraft, Chief Coroner, 11th Floor, Thomas Moore Building, RCJ, London WC2A 2LL chiefcoronersoffice@judiciary.gsi.gov.uk**
1	**CORONER** I am JOHN NIGEL BROADBRIDGE, Assistant Coroner for Western Area of North Yorkshire
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 2 February 2018 the Senior Coroner commenced an investigation into the death of ROBIN ANDREW JAMES MCEWAN ("Mr McEwan"), aged 29 years. The investigation concluded at the end of the inquest on 8 October 2018. The conclusion of the inquest was that: "On 26th January 2018, the deceased was found in the basement to his Harrogate home suspended by a belt around his neck, the other end of which was attached to a fixture. Despite emergency resuscitation and support at Harrogate Hospital, he was considered brain stem dead by 1st February 2018 and after support was agreed to be withdrawn, he died there at 06:37 hours, 2nd February 2018." The medical cause of death was determined as "1a Hypoxic brain injury due to 1b hanging" and that Mr McEwan died because of "Suicide".
4	**CIRCUMSTANCES OF THE DEATH** In the evening of 26 January 2018 Mr McEwan had joined workmates for drinks after work. On return to his home he spoke to his life partner while in the basement there; she had no reason to be concerned for him and went upstairs. He stayed in the basement but his partner returned a short time later to find him hanging. Emergency medical support was undertaken at Harrogate Hospital but care and treatment was withdrawn after it was clear the brain injury he had suffered was non survivable, and indeed after he became considered as 'brain stem dead'. Mr McEwan had previously consulted his GP from December 2017. His GP identified through standard screening tools that Mr McEwan presented with both severe anxiety and depression. Antidepressant medication was prescribed but was said not to be taken by Mr McEwan in consultation on 23 January 2018 when he reported his mood had improved and indeed presented then in apparent improvement to his GP. Mr McEwan has been using private counselling services for Cognitive Behaviour Therapy for some weeks but no written clinical reports or formal feedback on this therapy was received by the GP.

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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. – Within the contexts of a) Primary Care and b) acknowledgement that referral access to specialist mental health services is considerably delayed and c) recourse to private therapy was sought in the meantime pending any referral and d) there are resources that can be shared in the 'waiting' period then: (1) there was a disconnect in communication between that private therapy service and the GP. They were not sharing directly potentially key information that may have influenced concerns and decisions as to Mr Mc Ewan's welfare and safety; (2) there was evidence of regard to specific mental health approach and self help by the GP but it was stated that there were other approaches and in particular that a significant number of Health Trusts and CCGs reportedly subscribe to one known as "Zero Suicide Alliance"; (3) that there was no other guidance specifically to particular self help therapies that might be free of charge (or covered by the CCG if not), nor to online training package(s) for lay people supporting others experiencing suicidal crisis; (4) there might have been more exploration of potential support by and working with the patient's family to the intent that mental health 'scaffolding' was in place when no other professional help might be immediately available
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 5th December 2018. 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 will provide, at her request, a copy to the following Interested Persons – [redacted], mother to deceased. 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 10th October 2018 Signature JN Broadbridge Assistant Coroner for Western Area of North Yorkshire

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