

## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <p><b>1. Chief Executive – Coventry &amp; Warwickshire Partnership Trust</b></p>
1	<p><b>CORONER</b></p> <p>I am S McGovern, senior coroner, for the coroner area of Warwickshire</p>
2	<p><b>CORONER'S LEGAL POWERS</b></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.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 5 October 2018 I commenced an investigation into the death of Mylon Sheppard 49 years old. The investigation concluded at the end of the inquest on 17 January 2019. The conclusion of the inquest was suicide.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Mr Sheppard hanged himself at his home and was found on 3 October 2018. He had significant contact with the Trust from 5 June 2018</p>
5	<p><b><u>CORONER'S CONCERNS</u></b></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 <b>MATTERS OF CONCERN</b> are as follows. –</p> <ul style="list-style-type: none"><li>(1) Failure of any effective oversight of decisions made by duty workers.</li><li>(2) Failure to effectively manage waiting lists.</li><li>(3) Failure to have a clear process at the Day Hospital in respect of non attendance of patients.</li><li>(4) Failure to ensure that family members are including are care planning (where the patient is happy for that to happen).</li><li>(5) Failure to have a system in place that clearly identified GP boundaries and geographical boundaries in respect of local mental health services to minimise the risk of incorrect referrals to the wrong teams..</li></ul>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you as Chief</p>

	Executive of the Trust have the power to take such action.
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 15<sup>th</sup> March 2019. 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><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons (a) [REDACTED] (brother of Mylon Sheppard)</p> <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>17<sup>th</sup> January 2019  Senior Coroner S McGovern <i>S McGovern</i></p>