H M Senior Coroner for Gloucestershire
Ms Katy Skerrett

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) Shaun Clee, CEO, 2gether NHS Foundation Trust, Edward Jenner Court, 1010 Gloucester Business Park, Pioneer Avenue, Brockworth, Gloucester, GL3 4AW**
1	**CORONER** I am Katy Skerrett, Senior Coroner for Gloucestershire.
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 27th February 2018 I commenced an investigation into the death of Robert Glyn Hughes. The investigation concluded at the end of the inquest on the 29th January 2018. The conclusion of the inquest was suicide. The medical cause of death was 1A Hanging.
4	**CIRCUMSTANCES OF DEATH** Robert Glyn Hughes was a 67 year old man who lived alone. He had a long history of low mood, alcohol and diazepam dependence, and he had taken numerous overdoses in the past. He had been diagnosed with prostrate cancer and was struggling with the diagnosis and the side effects from the treatment. On the 26th January 2018 he took an overdose and was admitted to hospital. After treatment and assessment by the mental health liaison team he was discharged on the 30th January. On the 14th February 2018 Mr Hughes contacted the Crisis team expressing suicidal ideation. After a telephone assessment he agreed to contact his community mental health nurse, and his GP. On the 20th February 2018 the police were contacted by a concerned friend of Mr Hughes. Police attended at his property and forced entry. They found Mr Hughes hanging with a cord around his neck attached to the door in his bedroom. He was pronounced deceased at scene. Mr Hughes had left a suicide note in his living room. Police are satisfied there are no suspicious circumstances surrounding his death.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed a matter giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. Although it should be noted that I did not find this area of concern to be a causative factor in Mr Hughes' case. In the circumstances it is my statutory duty to report to you. The **MATTER OF CONCERN** is as follows. – (1) The triangle of care approach, where mental health team practitioners seek permission from the patient to approach the patient's family, is not consistently applied.
6	**ACTION SHOULD BE TAKEN** In my opinion 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 4pm 8th April 2019. 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) [redacted] 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 11th February 2019 Signature_____ Ms K Skerrett Senior Coroner for Gloucestershire