	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive** **Midlands Partnership NHS Foundation Trust** **Mr Neil Carr** **Trust Headquarters** **St. George's Hospital** **Corporation Street** **Stafford** **ST16 3SR**
1	**CORONER** I am Mr Andrew Haigh senior coroner for the coroner area of Staffordshire South
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 15 January 2019 I commenced an investigation into the death of Lindsey Bailey aged 35 years. The investigation concluded at the end of the inquest on 21 May 2019. The conclusion of the inquest was 'suicide while mentally unwell' with the cause of death being 'hanging'.
4	**CIRCUMSTANCES OF THE DEATH** Lindsey Bailey was living with her parents and her father found her dead in the garage of their home on 14th January 2019. She had hanged herself. She had recent engagement with psychiatric services and some risk of self-harm had been assessed but her death was not expected.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. Since the conclusion of the inquest the final version of the Serious Incident Review carried out by your Trust has come through but not all concerns have been covered. 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 **REMAINING MATTER OF CONCERN** is as follows. – At relevant times Ms Bailey did have mental capacity and was in agreement with information being shared with her parents. Reference was made to the Care Engagement Charter promulgated by the Trust. Despite this it appears that there

	was a significant lack in relevant information being shared with Ms Bailey's parents. While this may not have necessarily have prevented the death it could have assisted in the treatment path and certainly may be relevant in other cases.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 5th September. 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 Person – [redacted] the father of the deceased. I have also sent it to Chase Emotional Wellbeing 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	**Date** 11th **July 2019** ..... Andrew A Haigh HM Senior Coroner for Staffordshire (South) Coroner's Office No 1 Staffordshire Place Stafford ST16 2LP Tel No: 01785 276127 sscor@staffordshire.gov.uk