ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Bradford District Care NHS Foundation Trust**
1	**CORONER** I am Oliver Robert Longstaff, HM Assistant Coroner for the coroner area of West Yorkshire (Western District).
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 14th March 2018, I commenced an investigation into the death of Miles Glynn Naylor, aged 33. The investigation concluded at the end of the inquest on 31st January 2019. The conclusion of the inquest was that Mr Naylor's medically certified cause of death was 1a) Hanging, and the short form conclusion of the jury was Suicide.
4	**CIRCUMSTANCES OF THE DEATH** At the time of his death, Mr Naylor was a patient of the Bradford District Care NHS Foundation Trust, detained pursuant to the provisions of s.2 of the Mental Health Act 1983. He died in his room on the Oakdale Ward in Lynfield Mount Hospital, Daisy Hill, Bradford, having suspended himself from a ligature he had fashioned from his own trouser belt and wedged into the hinge pin side of the door to the room.
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 jury formally recorded their opinion as part of the conclusion to the inquest that the Bradford District Care NHS Foundation Trust should carry out a review of its management of its ligature risks from personal items. (2) During the course of evidence, questions were raised about the design of the doors on Oakdale ward, and whether access to the hinge pin side of the doors might be prevented by the use of covers similar to the finger guards in use in children's nurseries and similar premises.)

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 6th March 2020. 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] 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	**10th January 2020** Assistant Coroner