Worcestershire Coroner's Court
The Civic
Martins Way
Stourport on Severn
Worcestershire DY13 8UN

G U Williams LLB
HM Senior Coroner

My Ref: GUW/TW/W1365.15
Your Ref:

Date: 30 November 2015

Judge Peter Thornton QC
Chief Coroner's Office,
11th Floor Thomas More Building
Royal Courts of Justice,
Strand,
London,
WC2A 2LL

By Email only : chiefcoronersoffice@judiciary.gsi.gov.uk

Dear Sir

Re: Stephen Martin ADAMS deceased
Regulation 28: Report to Prevent Future Deaths

I enclose herewith my Regulation 28 Report to Prevent Future Deaths.

Yours sincerely

G U Williams

Enc:

T: 01905 766066 F: 01299 879238 coroner@worcestershire.gov.uk
www.whub.org.uk/HMCoroners

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. Worcestershire Health and Care NHS Trust** **2.** **3.**
1	**CORONER** I am Geraint Urias Williams, Senior Coroner, for the coroner area of Worcestershire
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 23rd June 2015 I commenced an investigation into the death of Stephen Martin ADAMS then aged 58 years. The investigation concluded at the end of the inquest on 23 November 2015. The conclusion of the inquest was suicide the medical cause of death being hanging .
4	**CIRCUMSTANCES OF THE DEATH** Mr Adams was being cared for by the Home Treatment Team of the Worcestershire Health and Care NHS Trust during which time he committed suicide by hanging himself at his home.
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) It emerged during the inquest that the Risk Assessment document completed by the Mental Health Liaison Team worker was not complete in as much as the box indicating the assessment of suicide risk had not been completed. The witness indicated that many workers do not complete this box and the assessment of risk is to be extrapolated from the actions taken by the worker. No where on the document is the assessment of risk to be found. (2) (3)
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 specifically to ensure that the assessment of risk is properly and fully recorded on the assessment paperwork.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 25th January 2016 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 Mrs Fox-Adams. I have also sent it to Chief Executive Trust, Chief Coroner 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	**Signed** **G U Williams** **H M Senior Coroner** **30th day of November 2015**