Her Majesty's Coroner
Staffordshire (South) Coroner's Jurisdiction

Date: 10 July 2020

Case: 2812588

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:
Stafford and Surrounds Clinical Commissioning Group
Midlands and Lancashire Commissioning Support Unit Springfields Health & Wellbeing Centre 19 Lovatt Court Rugeley WS15 2FH

CORONER
I am Mr Andrew A Haigh HM Senior Coroner for Staffordshire (South)

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST
On 2 March 2020 I commenced an investigation into the death of Gwilym Emrys PRICE. The investigation concluded at the end of the inquest on 9 July 2020. The conclusion of the inquest was 'Hanged himself while mentally unwell' with the death having resulted from hanging

CIRCUMSTANCES OF THE DEATH:
In May 2018 Mr Price suffered a physical injury and subsequently his mental health deteriorated. He had problems at work and received counselling and other treatment. He also had a shortage of sleep and was upset by an injury sustained by one of his children. On 25th February 2020 he was found hanging in the garage of his home in Gnosall. He was taken to Royal Stoke University Hospital but died there later the same day.

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. In the circumstances it is my statutory duty to report to you.

The **MATTER OF CONCERN** is as follows:

shortly prior to his death Emrys was referred by his GP to the Midland Partnership Foundation NHS Trust (MPFT) because of his psychiatric presentation. The GP did not use the type of referral form approved by the MPFT. I understand this has been previously circulated with a request that it is used but this has not yet taken place. I do not believe this affected the treatment that Emrys received but in other case it could lead to referrals being given an incorrect degree of priority.

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.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 7.9.2020 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:
Family
Midlands Partnership Foundation Trust

I have also sent it to other interested persons who may find it useful or of interest:
Other clinical commissioning groups
[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.

Dated : 10 July 2020

Signature

Andrew Haigh Senior Coroner for Staffordshire South