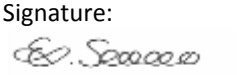
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] – Chief Executive** **NHS England** **PO Box 16738** **Redditch** **B97 9PT**
1	**CORONER** I am Emma Serrano Area Coroner for **Stoke-on-Trent & North Staffordshire Coroner's Court**
2	**CORONER'S LEGAL POWERS** 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 18 July 2019 I commenced an investigation into the death of Steven Clive Cooke, aged 56. The investigation concluded at the end of the inquest on 16th December 2020. The conclusion of the inquest was Steven Cooke was found, having passed away, on the 9 July 2019 at his home address of 1a Springfield Grove, Stoke-on-Trent, ST8 7BA. He hung himself by a ligature fashioned from a grey wiring cable fastened to the rafters in the loft. The cause of death recorded at inquest was: 1a) Hanging by ligature.
4	**CIRCUMSTANCES OF THE DEATH** Steven Cooke first presented to the Mental Health Services within Stoke-on-Trent on the 1 February 2019, after the breakdown of his marriage of 36 years. He was treated as an inpatient and within the community for this, until he passed away on the 9 July 2019. During the inquest it was accepted by the Trust that work was needed nationally regarding gaining input from a patient's family. Whilst it was accepted that patient's wishes for information not to be passed on had to be respected, this did not stop the Mental Health Services engaging with families to find out further information regarding a patient. Whilst Stoke-on-Trent Mental Health Services are mandated to engage with families of a patient to ascertain as much information as possible, this does not happen nationally. There is little in the way of national guidance and it will often depend on which area you live in, as to whether this takes place. .
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) That there is no national guidance regarding engagement with the family of a Mental Health patient to gain as full a picture as possible.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you NHS England 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 **25 February 2021**. 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. North Staffordshire Combined Healthcare NHS Trust 2. The family of Steven Cooke. I am also under a duty to send the Chief Coroner a copy of your response and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	30/12/2020 Signature:  **Emma Serrano, Area Coroner, Stoke-on-Trent & North Staffordshire**