Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted] – Chief Executive – Spire Harpenden Hospital** **2 Dr [redacted], Spires Harpenden Hospital**
1	**CORONER** I am M D FLEMING for the area of West Yorkshire Western Division
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 17 September 2021 I commenced an investigation into the death of Faizan Qadeer NAZAR aged 31. The investigation concluded at the end of the inquest on 29 March 2022. The conclusion of the inquest was that: On 13/09/21 Faizan Qadeer Nazar, who had a longstanding history of depression and anxiety, sustained fatal injures after deliberately [redacted] It is found more likely than not that he intended his own death and 3rd parties can be excluded.
4	**CIRCUMSTANCES OF THE DEATH** On 12/9/21, Faizan who had a known history of derpession an d anxiety was reported as missing by his family when he unexpectedly went missing from the family home. Subseqwuently he made his way to a [redacted] before deliberately lying [redacted] causing him to instaneously sustain fatal injuries
5	**CORONER'S CONCERNS** During the course of the inquest I heard evidence from Dr [redacted], Faisan's treating Consultant Psychiatrist who told me that it was not customary at Spire Harpenden Hospital to forward written reminders of a patients forthcoming appointments. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: • I would ask you to give consideration to the appropriateness of reviewing this practice.
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 May 27, 2022. 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 **Dr [redacted] - Father** **Dr [redacted] – Spire Harpenden Hospital** I may also send a copy of your response to any 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 by the Chief Coroner.
9	**Dated: 04/04/2022** **M D FLEMING** **HM Senior Coroner for** **West Yorkshire Western Coroner Area**