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 LPFT Legal Services** **2 NAViGO Grimsby** [redacted]
1	**CORONER** I am Paul COOPER, HM Assistant Coroner for the coroner area of Lincolnshire
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 04 November 2021 I commenced an investigation into the death of Vincenzo Joseph Michael LIPPOLIS aged 21. The investigation concluded at the end of the inquest on 26 October 2022. The conclusion of the inquest was that: The deceased died on 1st November 2021 at Sand Dunes, Quebec Road, Mablethorpe when he was found hanging in a woodland [redacted]
4	**CIRCUMSTANCES OF THE DEATH** 1.11.21 Pt reported missing to Police approx 0745 today by family Family and friends out looking today in Mablethorpe today and patient has contact with ?friends/family via phone and expressed suicide intentions Friends found pt hanging in woodland [redacted] Friends took him down and started CPR whilst another rang 999. o/a-Helimed/Police/Coastguard o/s- pt laid supine in woods-police and Helimed doing CPR-pt aystole-airway i gel size 4 inserted by helimed doctor-IV acess by helimed para right ACF-250 fluids given and 1 x adrenaline-pupils fixed and dilated-BM 4.8 Pt aystole-ALS for 7mins-pt aystole throughout All agreed futile-time of death 1009 Deep ligature marks to neck JF 2.11.21 Allocated CO Body Mapping PM Required Ligature with deceased at FD JF 3.11.21 Call to NOK to update Will confirm FD etc [redacted] Known to feel suicidal [redacted] x 4 previous suicide attempts Admitted to Grimsby at the beginning of October having fallen 20ft following hanging attempt out [redacted] Deceased sent a number text messages to family members telling them 'he loved them'

between 07.30-0800 on the morning prior to his death

JF 4.11.21
Prelim PM
Awaiting Tox
NOK updated
Investigation required
In light of circs, changed to inquest.

[redacted]
Note to HM Coroner to request authorisation to release property.

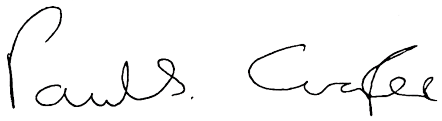
JF 29.11.21
[redacted]

JF 28.1.22
Tox report received
NOK updated
JF 02.02.2022
Final PM report
COD:
1a Hanging
NOK updated

[redacted]

JF 10.3.2022
Email to NOK to chase above note-rec'd.
JF 6.4.22
NOK confirmed that hospital will be asking questions about Vicenzo lack of treatment(unable to confirm the name of the person who said this-email in attachments) - Email to BS to request this is confirmed by DPOW
JF 30.4.22
Email recieved from NOK with name of the lady who advised her of the above 'lack of treatment'
JF 5.5.22
Referred to LPFT [redacted] for clarity.
[redacted] confirmed that following contact with Vincenzo(VL) on 17.10.21(as per LPFT report):
No SI undertaken-doesn't meet the criteria
Referred to Crisis team
VL agreed that drugs impact on his wellbeing
Referred to WAWY & EDAN(End domestic abuse) on 18.10.21
18.10.21 LPFT contacted GP to requested he make a welfare call to VL
Triaged as not suicidal / under the influence of anything
At the time of his death VL wasn't a client of LPFT
Discharged after contact on 17.10.21

	JF 12.10.22 Call to NOK to advise file being passed to PS for review etc. Unanswered, no message facility JF 13.10.22 Discusssed with PS - need MH report from [redacted] (saw him in A&E ON 16.10.22) JF 14.10.22 BS Emailed ; Report/statement requested from NAVIGO ([redacted]) - to include the answer to mums question JF 24.10.22 Comms with Mum - discussed the clinical notes from [redacted] - content that this answers her question. Able to attend hearing on 26.10.22
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. 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: (brief summary of matters of concern) In the NAVIGO report of 22nd October 2022 in response to the mother's request as to "why Vincenzo wasn't sectioned under the Mental Health Act after his detrimental (suicide) attempt on 16th October if only for observation" the SW replies "An admission to a mental health unit would not provide a therapeutic benefit as Vinny's social stressors would still be present in the future". The response does not seem to consider/reflect the admission criteria under s.2 or s.3 of the MHA. Please clarify the rational as the family believe an opportunity has been lost and a death could have been averted. In addition, the recommendation was for a face-to-face meeting with the deceased. Please explain why LPFT made only a telephone call on 17th October when if face to face observations and a more effective analysis had been undertaken particularly after the recent suicide attempts a more effective analysis could have been undertaken. As it was the case was closed on the same day.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 December 21, 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

	I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. 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: 26/10/2022**  **Paul COOPER** **HM Assistant Coroner for** **Lincolnshire**