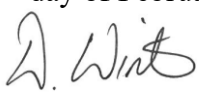
Derek Winter DL
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive of Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust**
1	**CORONER** I am Derek Winter DL, Senior Coroner for the City of Sunderland
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 8th April 2022 I commenced an Investigation into the death of Daniel Graeme Futers, who was born on 13th June 1990 and who died at the Wearmouth Bridge in Sunderland on 5th April 2022 aged 31 years. The Investigation concluded at the end of a 3-day Inquest on 1st February 2023. The conclusion of the Inquest was: 'Daniel Graeme Futers took his own life, in part because the complexity of his condition was not fully appreciated, and appropriate precautions were not in place to prevent him from doing so.' The medical cause of death was: - Ia Multiple Injuries Ib Fall From a Height II Schizoaffective disorder
4	**CIRCUMSTANCES OF THE DEATH** Daniel Graeme Futers died on 5th April 2022 at the Wearmouth Bridge, Sunderland [redacted], and fell to his death. There had been a number of failings in his Mental Health Care and treatment and in particular the management of his leave from Hopewood Park and his prospective discharge from state detention.

5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are, as follows: – 1. The recording of information, particularly that conveyed by telephone, was not as comprehensive as it ought to have been. For example, a record of an altercation had not been made. 2. Comprehensive planning for home leave and discharge from hospital was not evident, including contingency planning and the involvement of the family. 3. Overall situational awareness about Daniel was not evident, including the reconciliation of conflicting accounts about him.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 30th March 2023. 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: - • Family and their Solicitors and Counsel • Care Quality Commission (CQC) 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	Dated this 2nd day of February 2023 Signature  Senior Coroner for the City of Sunderland