REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **, Chief Executive of Midlands Partnership NHS Foundation Trust**
1	**CORONER** I am Catherine McKenna, Area Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 23 February 2023 an investigation into the death of Vaughan Lee WHALLEY (the Deceased) was commenced. The investigation concluded at the end of the inquest on 13 June 2023. I recorded a conclusion of **Suicide**
4	**CIRCUMSTANCES OF DEATH** At 22:38 hours on 19 February 2023, . He was found unresponsive the following morning and taken to the Royal Oldham Hospital where he underwent surgery to stem the extensive bleeding. Despite best supportive care, he died at the Royal Oldham Hospital on 21 February 2023. The Deceased had been released on bail from Worcester Police Station at 00:33 hours on 19 February 2023 after being detained for 24 hours. In the hours before his arrest, he had been identified by West Mercia Police as a high risk missing person because he had made threats to end his life. On arrival at the police station, the Custody Sergeant took steps to address the Deceased's risk of suicide by removing his belt, providing him with a rip proof blanket and making a referral to the Liaison and Diversion Service. The referral form included the fact that the Deceased had made threats to end his life. The Liaison and Diversion Practitioner (the Practitioner) attended the Deceased's cell at 10:03 hours on 18 February. A conversation took place through the observation hatch in the cell door which consisted of enquiring whether the Deceased wanted any help with unmet needs or vulnerabilities. During the conversation, the Deceased told the Practitioner that his thought of suicide had been a reaction to the allegations for which he was arrested and that these had now passed. The Court found that this conversation did not equate to a full assessment of the Deceased's risk of suicide or self-harm. Furthermore, the Practitioner indicated that it was not his role to assess whether the Deceased presented a risk of suicide or self-harm on release from custody. The Practitioner made no entry of his contact with the Deceased in the Detention Log. The Court found that there was a lack of clarity in the handover information given to the police as to what, if any, assessment had taken 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) No assessment of the risk of suicide or self-harm upon release took place during the Deceased's time in detention

(2) There was a lack of clear communication to the Police as to what, if any assessment had taken place.

(3) The conversation between the Practitioner and the Deceased took place through an observation hatch in circumstances where no risk was posed to the Practitioner from being in the same room as the Deceased. This was not best practice.

(4) The terminology used by the Practitioner was misleading in that it suggested that there was no role for the Liaison and Diversion service because no unmet needs or vulnerabilities had been identified. The evidence was that the Deceased had declined consent for an assessment of unmet needs and vulnerabilities and therefore the notes should have made clear that an assessment of unmet needs and vulnerabilities had not taken place.

(5) The 'review' undertaken by a Health & Justice Operational Manager of the West Mercia Health & Justice Service consisted of duplication of the Practitioners statement with no comment, observations or identification of areas of learning.

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 **9 August 2023.** I, the Area 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 namely:-

- [redacted] (family of the Deceased)
- Chief Constable of West Mercia Police
- Care Quality Commission

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 from. 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.

Date: 16 June '23 Signed: