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 Navigo**
1	**CORONER** I am Marianne JOHNSON, Assistant Coroner for the coroner area of North Lincolnshire and Grimsby
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 07 March 2022 I commenced an investigation into the death of Reece William NELSON aged 23. The investigation concluded at the end of the inquest on 05 December 2023. The conclusion of the inquest was that: Reece Nelson was found hanging [redacted] on the 28th February 2022 at his home address of Richmond Road, Grimsby. Paramedics attended and pronounced death.
4	**CIRCUMSTANCES OF THE DEATH** Reece Nelson was found hanging [redacted] on the 28th February 2022 at his home address of Richmond Road, Grimsby. Paramedics attended and pronounced death.
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) On the morning of Reece Nelson's death his family attempted to contact his Care Coordinator due to concerns regarding his mental state. The Care Coordinator was on sick leave, however this information was not reported to the family and therefore no return call was made to them. Had the family been made aware that the Care Coordinator was on sick leave they would have tried alternative routes to contact the mental health services to seek assistance. There should be a system in place whereby alternative contact details are provided in the event of a staff member being absent
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 February 02, 2024. 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 [redacted] I have also sent it to who may find it useful or of interest. 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: 12/12/2023**  **Marianne JOHNSON** **Assistant Coroner for** **North Lincolnshire and Grimsby**