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 Midlands Partnership Foundation Trust (MPFT)**
1	**CORONER** I am Andrew R. Barkley, Senior Coroner for the coroner area of Staffordshire and Stoke on Trent
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 23 March 2023 I commenced an investigation into the death of Jamie Peter Norman PILKINGTON aged 51. The investigation concluded at the end of the inquest on 13 February 2024. The conclusion of the inquest was that of "Road traffic collision"
4	**CIRCUMSTANCES OF THE DEATH** The deceased passed away in his vehicle which had left the road, struck a tree and caught fire in the early hours of the morning of 12th March 2023 on Port Lane, a short distance from Whitehouse Lane, Codsall, Staffordshire. He was confirmed deceased at the scene. He was, at the time of the collision, under the care of the Mental Health Services and had been expressing suicidal thoughts, something with which he had suffered for many years. There was no evidence to suggest that he left the road intentionally.
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) During a Mental Health triage with the the Mental Health and Social Inclusion Hub on 8th February 2023 there was a failure to complete the Risk Assessment in relation to his risk of suicide. When referred to and assessed by the Integrated Mental health Team on 3rd March 2023 again there was a failure to complete a Risk Assessment as to his risk of suicide. Furthermore, in an appointment on 3rd March 2023 1. Suicidal/self-harm thoughts not explored in detail. 2. There was no exploration of his statement to the effect he was actively researching methods of taking his own life.

	3. There was no exploration regarding efficacy/concordance with medication. 4. There was no discussion around distraction techniques, coping mechanisms or information about contact details for other services. 5. There was no discussion regarding his support network, next of kin etc. 6. There was no indication of next steps, timescales or when he could expect to be informed of the onward plan and no definite date when his case would be discussed with the Multi Disciplinary Team. On hearing evidence of the investigation into the Mental Health care which he received, beyond offering further training and support to nursing staff and mental health professionals, no assurance could be given of a system change to ensure that such Risk Assessments were completed or that appropriate and adequate exploration is made of matters which may affect how the risk of suicide is managed.
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 April 09, 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 I have also sent it to the family of the deceased 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:** **Andrew R. Barkley** **Senior Coroner for** **Staffordshire and Stoke on Trent**