ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive of Coventry and Warwickshire NHS Partnership Trust** **2. Department of Health -** [redacted] **3.** [redacted]**, sister of the deceased** **4. Chief Constable of Warwickshire Police**
1	**CORONER** I am Deborah Rachel Lakin, assistant coroner, for the coroner area of Coventry and Warwickshire.
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 12 May 2023 I commenced an investigation into the death of Narjit Gill, aged 61 years. The investigation concluded at the end of the inquest on 9 February 2024. The conclusion of the inquest was suicide, with the medical cause of death confirmed as hanging.
4	**CIRCUMSTANCES OF THE DEATH** 1. Mr Narjit Gill died on 5 May 2023, by hanging himself [redacted] 2. He had recently been in contact with mental health services, following reports to police from his friend, that he had attempted suicide. Mr Gill received a number of telephone calls, home visits and face to face appointments, commencing 24 April 2023 until his death. 3. Mr Gill was seen at his home by registered mental health practitioners, on 3 May 2023. During this visit, he disclosed that he continued to experience suicidal thoughts "on an almost constant basis", and he reported that he had attempted to ligate himself from a tree in the garden on a number of occasions and had also made an attempt to ligate from a stair rail within his home. 4. [redacted] 5. Mr Gill continued to express suicidal ideation, although he agreed to engage with Mental Health services, to attend all appointments and to take anti-depressant medication. 6. A home visit by the same mental health practitioners, was arranged for Mr Gill on 5 May 2023. Sadly, upon their arrival, Mr Gill was found to have ended his life by hanging himself [redacted].

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 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. – (1) Failure to remove [redacted] when it was seen on 3 May 2023 by mental health practitioners who visited Mr Gill at his home, in light of his continued expression of suicidal ideation.
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 5 April 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 Person, [redacted], sister of the deceased. I have also sent it to the Chief Constable of Warwickshire Police, who may find it useful or of interest. 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	**9 February 2024** **Deborah R Lakin**