



**ANDREW HETHERINGTON**  
**HM Senior Coroner for Northumberland**

**County Hall Morpeth Northumberland NE61 2EF**

Date: 1 May 2024

## **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**

**THIS REPORT IS BEING SENT TO: Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust**

**CORONER**

1

I am Mr Andrew Hetherington for Northumberland

### **CORONER'S LEGAL POWERS**

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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>

### **INVESTIGATION and INQUEST**

On 1 June 2023 I commenced an investigation into the death of Harry David HALL. The investigation concluded at the end of the inquest on 30 April 2024. The conclusion of the inquest was Suicide

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1a Intracranial Bleed

1b

1c

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### **CIRCUMSTANCES OF THE DEATH**

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Harry David Hall had a history of depression, mental health illness and had expressed recent suicidal ideation. In the period leading up to his death he had been researching various websites relating to suicide.

He was under the care of the West Northumberland Community Treatment Team and no in person assessment had taken place prior to his death.

At approximately 16.30 hours on 29 May 2023 in the rear garden of Croydon Cottage Thorngrafton

Hexham Northumberland he was found with a self-inflicted traumatic head injury the result of the firing of a captive bolt gun that he had recently purchased

### **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. -

#### **[BRIEF SUMMARY OF MATTERS OF CONCERN]**

5 (1) The deceased was seen by his General Practitioner on 27 March 2023 when he described ongoing suicidal ideation. His General Practitioner referred him to the 24-hour crisis team at 17.56 hours on 27 March 2023. The Initial Response Team ("IRT") provides 24 hour access to urgent mental health care and treatment. The IRT called the deceased at 22.37hrs on 27 March 2023 and I am told during which no immediate risks of self-harm were identified and although frequent thoughts of suicide were being experienced they were felt to be chronic in nature. The clinical decision was to not to refer on the Crisis Team and instead refer to the West Northumberland Community Treatment Team. There were two letters the first dated 31 March 2023 offering an appointment on 17 May 2023 and the second dated 4 April offering an appointment on 26 June 2023. I heard there was a ten week delay in appointments although that delay has since been rectified. The appointment on 17 May 2023 did not go ahead. No evidence was given as to why the appointment on the 17 May 2023 did not go ahead. There is nothing in the records, it is unclear if any assessment was undertaken at that time and this is crucial information. It is speculation if the outcome would have been any different if the deceased had been seen prior to his death. I am concerned with regard to the record keeping at this time.

#### **ACTION SHOULD BE TAKEN**

6 In my opinion action should be taken to prevent future deaths and I believe you **Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust** have the power to take such action.

#### **YOUR RESPONSE**

7 You are under a duty to respond to this report within 56 days of the date of this report, namely by 25 June 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.

#### **COPIES and PUBLICATION**

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Mr Hall's family

8 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.  
1 May 2024

9 Signature 

Andrew Hetherington HM Senior Coroner for Northumberland for