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 Radis Community Care**
1	**CORONER** I am Ian PEARS, HM Assistant Coroner for the coroner area of West Yorkshire Western Coroner Area
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 22 January 2024 I commenced an investigation into the death of Geoffrey Stuart CHENEY aged 71. The investigation concluded at the end of the inquest on 11 October 2024. The conclusion of the inquest was that: Geoffrey Stuart Cheney hung himself and a short form conclusion of suicide was recorded.
4	**CIRCUMSTANCES OF THE DEATH** On 8th November 2023 an initial assessment for home treatment was undertaken on Geoffrey Stuart Cheney by the Kirklees Outreach Team. In that assessment Geoffrey indicated that he regularly had suicidal thoughts, including [redacted] in his flat to hang himself. His family asked that [redacted] be removed. Geoffrey was admitted as a voluntary patient and after some time was deemed to be fit enough to have unescorted leave. He undertook that successfully on a number of occasions. On 16th January 2024 he went to his home at [redacted] on unescorted leave. He put the chain on the door and hung himself [redacted] that was still in place.
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) From the evidence it was clear that there was an assumption that [redacted] could not be removed and as a result no attempt was made to see if it was actually possible to have [redacted] removed

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 December 12, 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 **Pinnacle Group Limited** 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: 18/10/2024** **Ian PEARS** **HM Assistant Coroner for** **West Yorkshire Western Coroner Area**