

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 CEO, Oxford Health NHS Foundation Trust

1 CORONER

I am Robert SIMPSON, Assistant Coroner for the coroner area of Berkshire

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 09 February 2024 I commenced an investigation into the death of Jan Michael RACIBORSKI aged 62. The investigation concluded at the end of the inquest on 10 January 2025. The conclusion of the inquest was that:

On the 5th February 2024 Jan Michael Raciborski died at his home address in Caversham after he hung himself. He had suffered with mental health issues for the majority of his life which, along with the impact of a brain injury resulting from an historic attempt to end his life, significantly affected his mood and decision making processes.

4 CIRCUMSTANCES OF THE DEATH

Mr Raciborski suffered from depression and a brain injury for many years. This led to a complex presentation and he was under the care and treatment of the South Oxon Adult Mental Health Team (AMHT) from 2022. He had previously been sectioned, spent time as a voluntary patient and the mental health services had had involvement on and off over the past 40 years.

The AMHT worked closely with Mr Raciborski and he had both a care co-ordinator and support worker, as well as involvement with further staff members. He had many contacts with them during his final period of care.

He had a history of impulsive actions and intermittent suicidal thoughts. In August 2023 his condition deteriorated before then improving. In November 2023 this happened again and this presentation was in keeping with a pattern over the years.

In January 2024 he had a fleeting thought of suicide and was assessed by a mental health team in London. He subsequently had contact with his local AMHT. He remained distressed over the following days until he was found deceased on the 5th February 2024.

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)



None of the records of contact with Mr Raciborski completed by the AMHT in the period from August 2023 to the date of Mr Raciborski's death contained any written record of a risk assesment. I found that in Mr Raciborski's case this absence did not impact his treatment and was not a causative factor.

However my concern is that the failure to properly record the details of a risk assessment can lead to inadequate information sharing and the possibility of someone who relies upon the records gaining the wrong impression. In addition it does not allow the adequacy of the risk assessments to be properly investigated and could hinder investigations into deaths; which mean that a matter giving rise to a risk to life may not be identified in future investigations.

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 March 07, 2025. 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

Mr Raciborski's family.

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: 10/01/2025

Robert SIMPSON Assistant Coroner for

Berkshire

