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 [redacted], Chief Executive of Northamptonshire Healthcare Foundation Trust**
1	**CORONER** I am Anne PEMBER, Senior Coroner for the coroner area of Northamptonshire
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 03 January 2024 I commenced an investigation into the death of Shaun Kenny HALL aged 36. The investigation concluded at the end of the inquest on 29 January 2025. The conclusion of the inquest was: 1a Suicide
4	**CIRCUMSTANCES OF THE DEATH** Shaun Hall suffered with mixed anxiety, depressive disorder and emotionally unstable personality disorder. He regularly consulted his GP for these problems. On 2 November 2023 he attended A&E at Northampton General Hospital having taken an intentional overdose of olanzapine, tramadol and paracetamol. On the advice of his GP he self-referred to NHS Northamptonshire Talking Therapies on 13 November 2023. A telephone assessment took place on 20th November 2023. The Mental Health Support Practitioner was so concerned at Shaun's presentation that she made a referral to the Urgent Care and Assessment Team the following day. The referral was declined. Mr Hall was subsequently found deceased in the grounds of Whittlebury Hall on 14th December 2023 having hung himself. My conclusion was suicide.
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: The assessment from Talking Therapies on 20 November 2023 identified current escalating factors around not being allowed to see his children, and an upcoming court case in relation to this on 14 December 2023. Indeed he stated that if he was not allowed to see his children he would take his own life. Despite all this information being available the Urgent Care and Assessment Team did not accept the referral. Of grave concern is that the identity of the person at the Urgent Care and Assessment Team who declined the referral is not known and no notes were made of the referral.

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 27, 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 [redacted] 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: 30/01/2025** A. M. Pember **Anne PEMBER** **Senior Coroner for** **Northamptonshire**