REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Secretary of State for Health and Social Care**
1	**CORONER** I am Jyoti Gill, HM Assistant Coroner, for the coroner area of Manchester South
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 12th August 2024 an investigation commenced into the death of Sheridan Tate Pickett, age 27. The investigation concluded at the end of the inquest on 20th January 2025. The conclusion of the inquest was **suicide**. The medical cause of death was **1(a) multiple injuries consistent with a fall.**
4	**CIRCUMSTANCES OF THE DEATH** On 9th August 2024 Sheridan Pickett caused himself to fall from a height out of a window at [redacted] leading to him sustaining fatal injuries. A police investigation has determined there was no third-party involvement in his death.
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. The inquest heard evidence that Mr Pickett had a history of mental health issues and received an online diagnosis of ADHD from a private service provider (which prescribed Mr Pickett with medication too). Following his diagnosis Mr Pickett was admitted into an NHS hospital having taken an overdose. In their discharge letter the hospital suggested that the ADHD medication should not be recommenced. This information was not provided to the private ADHD provider which continued to prescribe Mr Pickett with ADHD medication. I am concerned that there are no current guidelines governing communication and information sharing as between private psychiatry providers offering assessment, care and treatment in relation to neurodiversity and NHS services involved with providing care and treatment in parallel.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 14th May 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 Pickett's mother and father on behalf of the family, Pennine Care NHS Foundation Trust 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 other 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	**Jyoti Gill** **HM Assistant Coroner**  **19th March 2025**