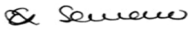
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Stoke Talking Therapies 2. Crisis Resolution Team 3. Midlands Partnership Foundation Trust
1	**CORONER** I am Emma Serrano, Area Coroner, for the coroner area of Staffordshire.
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 the 28th August 2024, I commenced an investigation into the death of Mr William Anthony Grieve. The investigation concluded at the end of the inquest on 17 March 2024. The conclusion of the inquest was a short for conclusion of suicide. The cause of death was: 1a Hanging
4	**CIRCUMSTANCES OF THE DEATH** i) Mr Grieve was found deceased, on the 20 August 2024, at his home address [redacted].
5	**<u>CORONER'S CONCERNS</u>** 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. – 1. Evidence emerged during the inquest that Mr Grieve was under the care of Stoke Talking Therapies, and had also presented at the Stoke crisis Evolution Team. Both had conducted suicide risk assessments of Mr Grieve. 2. Both assessments, were incorrect, and took account of incorrect information because neither team had access to the others computer system. Stoke Talking Therapies used IAPTUS and Crisis resolution used Lorenzo. There was no way for either team to see the others electronic notes. 3. It was said in evidence, that a member of staff had not carried out a risk assessment properly whoever, nothing had been done to address this

	and there were no plans to address this. The concern being that staff training needs are not being addressed.
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 7 May 2025. 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; 1. The family of William Grieve. 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.
9	**19 March 2025**  **Miss Emma Serrano** **Area Coroner** **Staffordshire**