REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, South West London and St Georges Hospitals NHS Trust**
1	**CORONER** I am Lydia Brown, Senior Coroner, for the coroner area of West London
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 30 August I opened 2023 an investigation into the death of **Jonathan Mark George Hamer DOB 7 August 1991, age 32.** The investigation concluded at the end of the inquest on 28 March 2025. Medical cause of death - 1a Head Injury The Conclusion was as follows:- Suicide
4	**CIRCUMSTANCES OF THE DEATH** Jonathan had been under the care of mental health services for many years and was diagnosed with bipolar affective disorder, for which he was prescribed medications and was under the community mental health team. He was living in supported housing but decided to seek alternative accommodation, also supported, towards the end of 2023. After this was facilitated, a new placement confirmed and his notice period served, he changed his mind but had to proceed with the move during March 2024. He was unhappy in his new accommodation and only stayed for a short number of days, spending time instead with his mother at her home. There were some gaps in his community mental health care due to staff leave and illness in early 2024, although he was seen during March and April. By 16 April he was not responding to telephone calls. At the time of his death he was not taking any of his prescribed medication. On 24 April 2024 he took his life by going onto the tracks in front of a train at [redacted], having sent his mother a text message confirming his intentions.

A st	**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. There were communication difficulties experienced by Jonathan's family and his supported housing with the community mental health trust responsible for his ongoing healthcare during the early part of 2024. Telephone calls and text messages were unanswered and there was no communication to confirm that in fact the care co-ordinator had a period of annual leave followed by an unplanned period of sick leave. It was unclear at inquest if service users and their support network had been provided with details of any service changes and current up to date contact details. This meant that important information was not being received by the community mental health team. 2. The community mental health team actively encouraged communication by text message and emails but had no system in place to intervene when the care co-ordinator was not at work and had left no "out of office" message. There was no system to return or redirect incoming calls or messages so these remained unread and unanswered. Those initiating the communication were unaware that the information was not being received or actioned by the Trust. 3. Jonathan's case was not "zoned" that is, given a priority coding on the case management system. Therefore, there was no expected period for case review or regularity of expected contact. The multi-disciplinary meetings and supervision meetings when Jonathan's case was discussed failed to recognise and address this issue. Appropriate zoning and regular reviews are a fundamental part of mental health care and should be embedded and prioritised as part of each patient's care planning.
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 13 June 2025 (allowing an extra week for the Easter break). 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 local safeguarding board where the deceased was under 18 and to the following Interested Persons Family members London Borough of Richmond upon Thames Way Through (formally Richmond Fellowship) 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 will 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. She may send a copy of this report to any person who she 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.
9	**[DATE] 10 April 2025** **[SIGNED BY CORONER]**