*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Medical Officer, NHS Cornwall and IoS ICB.
1	**CORONER** I am Andrew Cox, the Senior Coroner for the coroner area of Cornwall and the Isles of Scilly.
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 22/5/25, I concluded the inquest into the death of Callum James Hargreaves who died on 20/1/24 at the age of 32. I recorded the cause of death as 1a) Multiple Injuries. I recorded a conclusion that Callum died from suicide.
4	**CIRCUMSTANCES OF THE DEATH** Callum was sexually assaulted as a child. In his adult years, he developed substance misuse/addiction issues and it is likely he presented with complex PTSD or EUPD. He lived in social housing at Silverdale Court in Newquay. From approximately 2020, there started to be concerns that Callum was being cuckooed. In 2023, following the receipt of safeguarding alerts, it became apparent substantial damage had been caused at the flat which was uninhabitable. Callum was sleeping rough elsewhere. Temporary accommodation was arranged in Roche and Wadebridge but Callum was not allowed to remain at the addresses after drug paraphernalia was discovered. Callum continued to sleep rough apart from a short period when he was housed by the local authority under a severe weather protocol. In early 2024, a Notice Seeking Possession of the flat at Silverdale Court was served on Callum. On 19/1/24, Callum was seen in a distressed state having been involved in an altercation and complaining that his medication had been stolen. He went to a cliff edge in Newquay. Police attended and eventually removed Callum from the cliff. He was taken to a place of safety by police and underwent a mental health act assessment. He was determined not to be

	presenting with a severe and enduring mental illness of a nature and degree to warrant detention in hospital. Further, by the end of the period of assessment Callum's risk to himself was not felt to be sufficiently imminent or significant to justify short-term detention. Callum was discharged and provided with a taxi to take him back to his emergency accommodation. There was a discussion about whether Callum wanted members of his family informed of his discharge. Callum said that he did not and this decision was not tested or challenged. It was not felt appropriate to breach the duties of confidentiality owed to Callum in this regard. Callum's body was recovered from the sea at a location known locally as [redacted] in Newquay on 20/1/24. He had suffered multiple injuries consistent with a fall from height. Additionally, post-mortem toxicology revealed evidence of cocaine metabolites, diazepam, mirtazapene, pregabalin, zopiclone and methadone. The methadone in particular was at a high level and sufficient to have caused death on its own. The pregabalin and zopiclone were also present at high levels. On the evidence, I found it was more likely than not that Callum had jumped or fallen from the cliffs with the intention of ending his own life.
5	**CORONER'S CONCERNS** During the course of the inquest, the evidence has 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. I accepted independent expert evidence that the mental health act assessment had been thorough and appropriately concluded there were no grounds in law for detaining Callum. Additionally, I accepted evidence given by the clinicians that while NICE guidance did allow for short-term admissions to manage a period of crisis in a patient presenting with complex PTSD/EUPD, that was not indicated here. It was identified that the rationale for reaching that decision was not recorded in the notes. This is a matter I have taken up separately with those responsible for the AMHP. The **MATTERS OF CONCERN** relate to the arrangements made around Callum's discharge and, in particular, safety planning. 1) It was accepted in evidence that, owing to the decisions made by Callum, there were only limited options available to the clinicians. Of note, an offer to have personal follow-up by one of the clinicians involved in the assessment through the HTT was rejected. Additionally, the possibility of prescribing additional Diazepam was correctly discounted once it became evident Callum was already sourcing illicitly more than could be prescribed safely. 2) Callum refused permission for his mother (described as his rock) to be informed of his imminent discharge. On her evidence, she

	had been (wrongly) advised by police that her son would be detained and was safe. There was no evidence that this decision by Callum was explored or tested by the clinicians – instead it simply appeared to have been accepted by the clinicians without further enquiry. The independent expert was of the view that in a situation like this, where the assessing team had very few 'levers' available to it, Callum's mother was potentially one that could and should have been explored further. It was noted that GMC guidance allows for further enquiry, specifically that *58. If an adult patient who has capacity to make the decision refuses to consent to information being disclosed that you consider necessary for their protection, you should explore their reasons for this. It may be appropriate to encourage the patient to consent to the disclosure and to warn them of the risks of refusing to consent.* It was noted that the Nearest Relative's details appeared not to have been completed on the MH 1. Again, this is a matter that has been brought to the attention of those responsible for the AMHP.
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 25.7.25. 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: - Callum's family - Sanctuary Housing - Cornwall Council 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	**[DATE]** **29.5.25**	**[SIGNED BY CORONER]**