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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], Cornwall Council
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, it is more likely than not that Callum has jumped or fallen from the cliffs with the intention of ending his own life.
5	**CORONER'S CONCERNS** During the course of these inquests, 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. The **MATTERS OF CONCERN** are as follows. At inquest, the court heard from Gail Ashton who was the AMHP involved in the mental health act assessment conducted overnight on 19 & 20 January 2024. 1) One issue that arose was whether Callum presented with an imminent and significant risk of harm to justify a short-term admission into hospital as is provided for in NICE guidance. Ms Ashton said this was expressly discussed by the clinicians concerned. It was felt he was likely to be withdrawing and there were no resuscitation facilities available in Longreach. She also said the vulnerabilities of others on the ward needed to be considered all of which contributed to the decision not to detain Callum in hospital. She accepted that this rationale was not recorded in the notes. 2) Callum was asked whether he wanted his mother (who he described as his rock) notified of his discharge. He said that he did not. This was not tested or challenged where GMC guidance is that it may be appropriate to do so. The Nearest Relative details on the MH 1 form were not

	completed. The expert who reviewed the case felt there were 'obvious gaps' in the record keeping and that as Callum's mother was one of the few levers available to the assessing team, Callum's decision not to involve her should have been explored further. You may feel these omissions should be learned from when assessments are conducted in the future and, in particular, when notes of an assessment are subsequently recorded.
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: - [redacted], mother - [redacted], father and step-mother - Cornwall Partnership Foundation Trust - Sanctuary Housing 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]** **[SIGNED BY CORONER]** **28.5.25**