H M Area Coroner for Gloucestershire
Mr Roland Wooderson

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Gloucestershire Health and Care NHS Foundation Trust**
1	**CORONER** I am Roland Wooderson Area Coroner for the coroner area of Gloucestershire
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 23 May 2023 I commenced an investigation into the death of CALLAN NORMAN COLLINS ATKINS. The investigation concluded at the end of the inquest on 26 June 2025. The conclusion of the inquest was as set out below.
4	**CIRCUMSTANCES OF THE DEATH** On 18 May 2023 Callan was found hanging from a rafter at his home address. He was confirmed dead at the scene by a paramedic. The Police confirmed that there was no third-party involvement. He had recently undergone neurosurgery for epilepsy and believed that this had worsened his medical condition. His family considered that, at the time of his death, he was in a negative mindset and was constantly thinking about ending his life. It was clear that Callan took his own life and intended to so do. At the time of his death Callan was receiving assistance from clinicians in the NHS Mental Health Intermediate Care Team. There was a telephone appointment held between a member of that team and the deceased on 17 May 2023. Thereafter, an arrangement was made for a clinician from the mental health Crisis team to contact Callan on 18 May 2023 to arrange a face-to-face visit. A subsequent enquiry concluded that there was an opportunity missed to conduct a face-to-face assessment on 17 May 2023 between Callan and a member of the Crisis team. This would have been the ideal position. This was not possible due to the Crisis team's high clinical workload on 17 May 2023 albeit the Crisis team could have explored whether clinical agency staff were available to supplement the staff on 17 May 2023. However, the evidence did not disclose that there was any possible or probable contribution to Callan's death flowing from the Crisis team not seeing Callan on 17 May 2023.

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. – • That staff capacity of the mental health crisis team of the Gloucestershire Health and Care NHS Foundation Trust will dictate whether a patient is assessed on the same day when their clinical needs demand they are. • That the Trust will not make any enquiries as to additional resources when their local Crisis team has no capacity.
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 21 August 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: the Family and Gloucestershire Health and Care NHS Foundation Trust 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	**26 June 2025 Area Coroner Roland Wooderson**