MISS N PERSAUD
HIS MAJESTY'S CORONER
EAST LONDON
EAST LONDON CORONERS, 124 Queens Road, Walthamstow, London E17 8QP
Telephone 020 8496 5000 Email coroners@walthamforest.gov.uk

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

Ref: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Department of Health & Social Care:** [redacted] **Clinical Effectiveness Group, Queen Mary's University of London** **Sent via email:** [redacted]
1	**CORONER** I am Nadia Persaud, Area Coroner for the coroner area of East 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 6 January 2025 I commenced an investigation into the death of Daniel Norman Hatchett, aged 64 at the time of his death. The investigation concluded at the end of the inquest on 26 June 2025 with a conclusion of suicide.
4	**CIRCUMSTANCES OF THE DEATH** Mr. Daniel Hatchett had no history of mental health diagnoses. In the last few years of his life he suffered a decline in his physical health (most notably due to dilated cardiomyopathy, chronic kidney disease and atrial fibrillation), which together with

	work stresses caused a decline in his mental health. He attended a holistic BUPA assessment in December 2023. The BUPA report highlighted stress levels and a new diagnosis of atrial fibrillation which required prompt attention. Both health concerns were reported to Mr. Hatchett's general practitioner. In response to the BUPA report, Mr. Hatchett's GP directed him to A&E to obtain urgent treatment for the atrial fibrillation. Treatment was provided by the A&E team in the form of anticoagulation. The GP surgery did not action the recommendation for primary care psychotherapy and/or follow-up of his mental health to address his levels of stress. Mr. Hatchett did not present to any of the healthcare professionals as being at risk of suicide or at risk of deliberate self-harm, but he was not expressly questioned about his mental health. There was a missed opportunity to refer him for therapy in January 2024 and/or for the GP to follow up on Mr. Hatchett's mental health. It is not possible to conclude on the balance of probabilities that this would have prevented his death in November 2024. In the very early hours of the 9 November 2024 Mr. Hatchett was discovered hanging in his home address. Paramedics attended and pronounced his life extinct on scene. Police attended, investigated and deemed the circumstances as non-suspicious.
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: 1. Patients with chronic disease often present with concomitant mental health decline. 2. GP appointment timings are often insufficient for the necessary holistic review of this cohort of patients. 3. Templates for GPs, to assist them in reviewing patients with chronic disease, do not include a section for review of mental health. It was considered that such a requirement could assist in identifying patients whose mental health has been adversely affected by declining physical health. This would allow the opportunity for necessary mental health support to be offered to these patients. 4. The inquest heard that it is well known that middle aged men infrequently open up to their GP to express concerns about their mental health. An express question on a chronic disease review could help to elicit concerns that would otherwise remain undiscovered.
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 **31 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 am sending a copy of my report to the Chief Coroner, to the family of Mr Hatchett, to the CQC, to the local Director for Public Health and to Mr Hatchett's general practitioner.

	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 may 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. 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.
9	**4 July 2025**