ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. South West Yorkshire Partnership NHS Foundation Trust**
1	**CORONER** I am Abigail Combes, assistant coroner, for the coroner area of South Yorkshire (West District)
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 26 April 2022 I commenced an investigation into the death of Mark Ravensdale born on 2 January 1967. The investigation concluded at the end of the inquest on 2 February 2023. The conclusion of the inquest was:- Death by suicide The medical cause of death was: 1a: Hanging
4	**CIRCUMSTANCES OF THE DEATH** Mark Ravensdale had suffered with mental health conditions for a long period of time. Following one attempt to die by suicide he was placed into a care setting in order to support him before being moved into his own premises. He had a number of difficulties within that setting and continued to suffer with mental health challenges. His GP referred him into mental health services for assessment however when the services made contact with the home he was residing in Mark was not present at the home. The workers spoke to care staff but did not follow up with Mark afterwards and discharged him without speaking to him at any point. Shortly after this Mark was found hanged and his death was by suicide.
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. –

	There were no attempts by mental health services to speak to Mark directly to properly and adequately assess his mental health condition.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 11 July 2023. 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] and South West Yorkshire Partnership NHS Foundation Trust. 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. In this case I have sent a copy of this report to the CQC and South Yorkshire Integrated Care Board. 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	**16 May 2023** **Abigail Combes**