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. [redacted], Associate Director of Nursing and Quality – Mental Health Directorate**
1	**CORONER** I am Deborah Lakin, assistant coroner, for the coroner area of Coventry
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 12 January 2026 I commenced an investigation into the death of Wayne Pierce Walton, aged 45 years. The investigation concluded at the end of the inquest on 16 January 2026. The conclusion of the inquest was suicide, the date of death was 29 June 2024, the medical cause of death being asphyxiation.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased had been discharged from the Caludon Centre on 21 June 2024, where he had been an informal inpatient for a short period, having taken an overdose on 8 June 2024 with the intention of ending his life. The Deceased was discharged at his request on 21 June 2024, into the care of the community mental health Home Treatment Team, but he failed to engage and declined to attend for a 48 hour follow up appointment until 1 July 2024. The Deceased engaged sporadically with the Home Treatment Team and ultimately ended his life by asphyxiation on 29 June 2024.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) Staff involved in the decision-making process for a patient's discharge as an inpatient, into the care of the Home Treatment Team, were unaware of the policies applicable to the Home Treatment Team and were therefore unaware of the requisite information that should have been added into Risk Assessments and Safety Plans for the benefit of their colleagues in the Home Treatment Team. As risk assessment and risk formulation documentation had not been adequately completed, the Home Treatment Team were not able to identify a full and up to date risk analysis. Had the inpatient staff been aware of the importance of these documents for their colleagues'

	benefit, in addition to the need for accurate completion for internal reasons, there was a risk that important information was not passed on. (2)There is in existence, a policy entitled “Personal Relationships at Work” which addresses personal relationships of a particular type, but which does not address the potential for a conflict of interest when a member of staff, or a person shadowing a member of staff, recognises that they may know a patient other than because of a personal relationship as envisaged in the aforementioned policy. The absence of guidance on how to manage this situation, may place both the member of staff and the patient at risk of harm.
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 9 March 2026. 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 :Next of kin and Coventry City Council. 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	**16 January 2026** **Deborah R Lakin**