Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Oxford Health NHS Foundation Trust**
1	**CORONER** I am Crispin Giles BUTLER, Senior Coroner for the coroner area of Buckinghamshire
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 15 April 2024 I commenced an investigation into the death of Barry HARMER aged 68. The investigation concluded at the end of the inquest on 23 January 2026. The conclusion of the inquest was that:
4	**CIRCUMSTANCES OF THE DEATH** Barry Harmer was sadly found deceased at home at around 5am on 11th April 2024. Barry had died from the neck injury which he had likely inflicted upon himself earlier that morning, with [redacted]e had managed to retrieve from the locked garage. Barry had given most recent indications not only that he was thinking of ending his life, but that he would use this method, and he would not tell his wife beforehand. On balance, Barry undertook the act which ended his life and intended his death to result at this time. Barry was open to local community mental health services and a plan had been formulated with Barry and his family on 8th April 2024 requiring a voluntary admission to the local psychiatric hospital in Aylesbury, to which Barry had agreed. It was an essential part of that plan, until Barry could be offered a bed, that Barry remained at home under the community team, on Sertraline medication and subsequently with the assistance of Lorazepam. The family were not made sufficiently aware of the effects of this medication in understanding the reality of Barry's presentation. Although a bed was required for Barry in order to implement the plan for voluntary admission, and the written request was submitted on the afternoon of 8th April 2024, this was not actively pursued the following day and the family were not made aware of the likelihood of a bed being made available that day, or subsequently. Further, and as a consequence, the family were not made aware of the continuing significant burden in the plan to keep Barry safe at home that they needed to carry, irrespective of how he might have appeared to have improved on 10th April 2024. Although a first face-to-face psychiatric review was scheduled to take place on 11th April 2024, Barry had been known to the local community mental health team from triage on 26th March 2024 and his mental condition had clearly deteriorated in early April culminating in a visit to Accident & Emergency at Stoke Mandeville Hospital on the evening of 7th April 2024. That deterioration did not lead to any earlier consideration of a face-to-face psychiatric review
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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) Whilst evidence was given at the Inquest of fresh and additional learning that had arisen during the coronial investigation and as a result of the evidence given in person by Oxford Health staff and others, it was clear that the initial Incident Learning Huddle and subsequent Patient Safety Incident Investigation (PSII) undertaken in 2024 lacked robustness and did not appear to have been revisited in the light of the emerging family concerns and evolving evidence during the coronial investigation. The need for proactive backwards reflection on internal investigations is essential in informing learning going forward. (2) At the Inquest there was variable evidence as to the operation of the daily Patient Flow Meetings, during which patients requiring beds would be matched to availability based on individual needs. Communication to families of issues or obstructions to bed availability and reinforcement of safety plans during any period of wait for a bed should be a central feature of these daily meetings. (3) The fact that Barry had not had any face to face psychiatric review at any point during the time he was open to Oxford Health was not addressed in the PSII and it remains unclear how this can be escalated for immediate attention in the community, where circumstances are changing, where the need for a voluntary admission has been agreed, but no bed is available. (4) Evidence confirms that Oxford Health has access to the same Trust bed spaces in Buckinghamshire and Oxfordshire for detained and voluntary patients, within and without the older adult criteria, however the evidence indicated that bed availability as part of an agreed or prescribed care and treatment plan remains a significant issue. (5) Evidence from Oxford Health, acknowledged in a candid manner, that the Trust had listened to witnesses and the family during the Inquest and there was more to be taken back to identify further actions to be implemented. The broader issues of consistent understanding within and between Trust teams and with proactive communication with patients in the community and their families will remain of concern if they are not addressed in policy and training going forward. The very fact that learning was still being discussed and identified in January 2026 when Barry died in April 2024 indicates the importance of the timely implementation of identified actions
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 April 09, 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 The family of Barry Harmer and their legal representatives

	Buckinghamshire Council via their legal representatives 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 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 by the Chief Coroner.
9	**Dated: 12/02/2026** [redacted] **Crispin Giles BUTLER** **Senior Coroner for** **Buckinghamshire**