



## Regulation 28: REPORT TO PREVENT FUTURE DEATHS

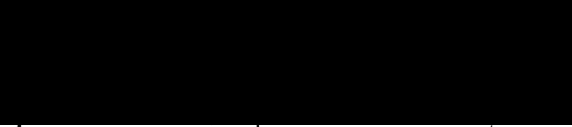
NOTE: This form is to be used **after** an inquest.

	<p><b>REGULATION 28 REPORT TO PREVENT DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <p><b>1 South West Yorkshire Partnership NHS Foundation Trust (SWYPT)</b></p>
<b>1</b>	<p><b>CORONER</b> I am Peter Merchant, an Assistant Coroner for West Yorkshire (Western) jurisdiction.</p>
<b>2</b>	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
<b>3</b>	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 19 December 2024 I commenced an investigation into the death of Richard Mark WHELAN aged 54. The investigation concluded at the end of the inquest on 02 April 2026 and the conclusion of the inquest was that:</p> <p>Richard Mark Whelan's death was confirmed at 14.30 hours on 15 December 2024 at his property [REDACTED]. His death arose from exsanguination from incised wounds to both wrists. This was a deliberate act undertaken with the intention of ending his life although he subsequently made an attempt to rescue himself by leaving his property before collapsing on the pathway to his property. Subsequent attempts at CPR were unsuccessful.</p> <p>In the preceding weeks before his death there had been a deterioration in his mental health. An assessment by a Mental Health Practitioner did not identify the risk to warrant either an admission to hospital or further support from Mental Health Services, but with the agreement of Richard, who had capacity, a Crisis Plan was formulated which Richard chose not to use.</p>
<b>4</b>	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Richard Mark Whelan's death was confirmed at 14.30 hours on 15 December 2024 at his property 23 Greenacres, Sowerby Bridge. His death arose from exsanguination from incised wounds to both wrists. This was a deliberate act undertaken with the intention of ending his life although he subsequently made an attempt to rescue himself by leaving his property before collapsing on the pathway to his property. Subsequent attempts at CPR were unsuccessful.</p> <p>In the preceding weeks before his death there had been a deterioration in his mental health. As assessment by a Mental Health Practitioner did not identify the risk to warrant either an admission to hospital or further support from Mental Health Services, but with the agreement of Richard, who had capacity, a Crisis Plan was formulated which Richard chose not to use.</p> <p>In the time prior to his death, on 10 December 2024, he had disclosed that on 07 December 2024, he had taken an overdose with the intention of ending his life. On 10 December 2024, a neighbour had contacted his GP surgery expressing a concern for his welfare, resulting in the attendance at his address of two receptionists from the GP surgery and an ambulance crew. He had also been in close contact with a Neighbourhood Housing Officer. This resulted, with his consent, in a referral by the Neighbourhood Housing Officer</p>



	<p>to the Mental Health Trust Single Point of Access (SPA) Service on 11 December 2024. By the time of his death no action had been taken in respect of the referral. Evidence at the inquest suggested that a triage of any non-urgent referral may take up to 14 days and thereafter once triaged an initial plan to engage may be devised dependent upon the outcome of the triage.</p>
<b>5</b>	<p><b>CORONER'S CONCERNS</b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows:</p> <p>Evidence at the inquest indicated that any referral to SPA classed as non-urgent may take up to 14 days to triage reflecting the SPA Standard Operating Procedure. The referrals to SPA could come from anyone, not necessarily someone with experience of mental health conditions. It was only following a triage of a referral and the outcome of the triage would a plan be devised to take forward a referral.</p>
<b>6</b>	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>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. The concern is the length of time take to triage such referrals. Recognising this is not only a provider but also a commissioning issue I will be copying this report to the Commissioners of the service.</p>
<b>7</b>	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 02 June, 2026. I, the Coroner, may extend the period.</p> <p>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.</p>
<b>8</b>	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner of England &amp; Wales and to the following Interested Persons:</p> <p>██████████</p> <p><b>South West Yorkshire Partnership NHS Foundation Trust</b></p> <p>I have also sent a copy of my report to:</p> <p><b>West Yorkshire Integrated Care Board</b></p> <p>who may find it useful or of interest.</p> <p>I am also under a duty to send a copy of your response to the Chief Coroner of England &amp; Wales and all interested persons who in my opinion should receive it.</p> <p>I may also send a copy of your response to any person who I believe may find it useful or of interest.</p> <p>The Chief Coroner of England &amp; Wales may publish either or both in a complete or redacted or summary form. The Chief Coroner of England &amp; Wales may send a copy of this report to any person who she believes may find it useful or of interest.</p>



	<p>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 of England &amp; Wales.</p>
<b>9</b>	<p><b>Dated: 09/04/2026</b></p> <p></p> <p><b>Peter MERCHANT</b> <b>HM Assistant Coroner for</b> <b>West Yorkshire Western Coroner Area</b></p>