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 Secretary of State for Health and Social Care**
1	**CORONER** I am Hassan SHAH, Assistant Coroner for the coroner area of Northamptonshire
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 17 November 2021 I commenced an investigation into the death of Mr Robin Andrew Ward. The investigation concluded at the end of an inquest on 17 October 2024. The medical cause of death was determined to be:- 1A - Drowning 2 - Hypertensive heart disease
4	**CIRCUMSTANCES OF THE DEATH** Mr Ward was a 73 year old man who died 4th July 2021 at the Warren Crisis House as a result of drowning in a bath. The conclusion was that his death was a result of Suicide. Mr Ward required an acute inpatient stay at a mental health hospital but no local beds were available until four days later. He was placed in the Warren Crisis House as an interim measure. There were safeguarding concerns in relation to his own home environment and placement at the Warren was considered the next best option in the absence of an inpatient hospital bed.
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) a) The Deputy Director for Mental Health at Northamptonshire Healthcare Foundation Trust said in his evidence "there are increasing pressures both locally and nationally with regards to the provision of acute mental health beds". b) The Deputy Director also said that "we try to avoid supporting those waiting for an acute bed within crisis houses and continue to use out of area provisions as required and where appropriate". However, it emerged in evidence that there are also pressures locally and nationally on the availability of out of area acute beds and that is particularly so in relation to provision for the elderly. Even if out of area beds are found, they can be a great

	distance away from the patient's home address which can present difficulties including in relation to continuity of treatment. In Mr Ward's case he was having rTMS treatment during each week day and that treatment is not available in all areas of the Country. This increases the likelihood that a crisis house may be utilised. However a crisis house does not offer the same level of clinical capacity and skills mix as a hospital environment and it is also not a ligature safe environment. c) Another particular problem identified was the long waiting times for psychological assessment.
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 **December 16th 2024**. 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] **Northamptonshire Healthcare NHS Foundation Trust** Similarly, you are under a duty to send the Chief Coroner a copy of your response. 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. about the release or the publication of your response by the Chief Coroner.
9	**Dated: 18/10/2024** [redacted] **Hassan SHAH** **Assistant Coroner for Northamptonshire**