ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Cambridgeshire & Peterborough NHS Foundation Trust**
1	**CORONER** I am William Morris senior coroner, for the coroner area of North & East Cambridgeshire
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 29th November 2012 I commenced an investigation into the death of Christopher James MORGAN aged 39 years. The investigation concluded at the end of the inquest on Friday 27th September 2013. The conclusion of the inquest was that Christopher James Morgan died on 27th November 2013 at Ely Railway Station; the cause of his death was multiple injuries. I recorded a narrative verdict (see below)
4	**CIRCUMSTANCES OF THE DEATH** Narrative Verdict : Christopher Morgan, a voluntary patient at Friends Ward, Fulbourn Hospital, Cambridgeshire, took his own life, dying from multiple injuries when he dived in front of a train at or near Ely Railway Station, on 27th November 2012, in circumstances where he had run away from Fulbourn Hospital earlier in the day and in circumstances where there was not in place in the hospital a formal risk assessment covering his supervision at the material time.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – • That before any change in identified level of risk is decided upon, particularly in relation to access to leave, there is communication with all relevant parties concerned including family and carers to elicit their views. • The Trust should ensure that a clear practice and policy is adopted in relation to the ratio of staff to patient as to staff that should accompany patients on escorted leave from psychiatric wards
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe that 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 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 [redacted] Interested Persons : [redacted] I am also 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 by the Chief Coroner.
9	**[DATE]** 22.Oct 2013. **[SIGNED BY CORONER]** [signature]