

## ANNEX A

### REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

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|   | <b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b><br><br><b>THIS REPORT IS BEING SENT TO:</b><br><br>1. [NAME]<br>2. [NAME]<br>3. [NAME]   |
| 1 | <b>CORONER</b><br><br>I am [NAME], senior coroner/area coroner/assistant coroner, for the coroner area of [NAME OF AREA]  |
| 2 | <b>CORONER'S LEGAL POWERS</b><br><br>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.<br>[HYPERLINKS]  |
| 3 | <b>INVESTIGATION and INQUEST</b><br><br>On [DATE] I commenced an investigation into the death of [NAME, AGE]. The investigation concluded at the end of the inquest on [DATE]. The conclusion of the inquest was [CONCLUSIONS including medical cause of death and short-form conclusion or narrative conclusion summarised].   |
| 4 | <b>CIRCUMSTANCES OF THE DEATH</b><br><br>[BRIEF SUMMARY]  |
| 5 | <b><u>CORONER'S CONCERNS</u></b><br><br>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.<br><br>The <b>MATTERS OF CONCERN</b> are as follows. –<br><br>[BRIEF SUMMARY OF MATTERS OF CONCERN]<br>(1)<br>(2)<br>(3) |
| 6 | <b>ACTION SHOULD BE TAKEN</b><br><br>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 | <b>YOUR RESPONSE</b><br><br>You are under a duty to respond to this report within 56 days of the date of this report,   |

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|   | <p>namely by [DATE]. 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>   |
| 8 | <p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [NAMES] [and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. I have also sent it to [NAMED PERSON] who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p> |
| 9 | <p><b>[DATE]</b> <b>[SIGNED BY CORONER]</b></p>  |

## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (2)

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

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|   | <p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <p>1. [NAME]<br/>2. [NAME]<br/>3. [NAME]</p>   |
| 1 | <p><b>CORONER</b></p> <p>I am [NAME], senior coroner/area coroner/assistant coroner, for the coroner area of [NAME OF AREA]</p>  |
| 2 | <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.<br/>[HYPERLINKS]</p> |
| 3 | <p><b>INVESTIGATION</b></p> <p>On [DATE] I commenced an investigation into the death of [NAME, AGE]. The investigation has not yet concluded and the inquest has not yet been heard.</p>   |
| 4 | <p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>[BRIEF SUMMARY]</p>  |

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| 5 | <p><b><u>CORONER'S CONCERNS</u></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>[BRIEF SUMMARY OF MATTERS OF CONCERN]</p> <p>(1)</p> <p>(2)</p> <p>(3)</p>   |
| 6 | <p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion urgent action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action.</p>  |
| 7 | <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 [DATE]. 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>   |
| 8 | <p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [NAMES] [and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. I have also sent it to [NAMED PERSON] who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p> |
| 9 | <p>[DATE] <span style="float: right;">[SIGNED BY CORONER]</span></p>   |

**SPECIMEN: REPORT TO PREVENT FUTURE DEATHS (1)**

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|   | <p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <ol style="list-style-type: none"><li>1. GP Surgery [ADDRESS]</li><li>2. Chief Executive, XYZ Mental Health Foundation Trust</li><li>3. Secretary of State for Health, Department of Health</li></ol>  |
| 1 | <p><b>CORONER</b></p> <p>I am JOHN DAVID SMITH, senior coroner, for the coroner area of [NAME OF AREA].</p>  |
| 2 | <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.<br/>[HYPERLINKS]</p>   |
| 3 | <p><b>INVESTIGATION and INQUEST [the details below are fictional]</b></p> <p>On 18 June 2013 I commenced an investigation into the death of JANE JANET JONES, then aged 34. The investigation concluded at the end of the inquest on 16 October 2013. The conclusion of the inquest was suicide, the medical cause of death being multiple injuries.</p>   |
| 4 | <p><b>CIRCUMSTANCES OF THE DEATH</b></p> <ol style="list-style-type: none"><li>(1) Jane had previously been living with her family in B-town. She had a history of psychiatric illness, but had never been an inpatient.</li><li>(2) On 3 June 2013, feeling that she needed a change, she moved into bed-sitter accommodation in C-town.</li><li>(3) She attended a local GP surgery in C-town on 7 June 2013 and said she felt suicidal. She was prescribed medication and referred to the local Mental Health NHS Foundation Trust. The referral was made by telephone on 7 June and by fax on 8 June.</li><li>(4) The Trust made no attempt to contact her in any way before her death.</li><li>(5) On 17 June 2013 Jane left her home in C-town and drove to Beachcombe Head, A-county. Her body was recovered from the foot of the cliffs on 18 June. There was no evidence to suggest that any other person was involved in her death.</li></ol>  |
| 5 | <p><b><u>CORONER'S CONCERNS</u></b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <ol style="list-style-type: none"><li>(1) The local Mental Health NHS Foundation Trust did not contact Jane in any way between the date of referral and her death. There was no attempt to contact her and no attempt to arrange an appointment.</li><li>(2) There was no follow-up to the referral by the GP surgery. No attempt was made to ensure that Jane had made an appointment with the Trust.</li><li>(3) Evidence was given at the inquest that there was no procedure or policy in place at the Trust to follow up GP referrals particularly where there was likely to be a degree of urgency.</li><li>(4) Evidence was given at the inquest that there was in place at the GP surgery a policy to follow up urgent referrals of a mental health nature but that present</li></ol> |

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|   | staff were not apparently aware of that policy.  |
| 6 | <p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe each of you, respectively, have the power to take such action.</p>   |
| 7 | <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 [DATE]. 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>   |
| 8 | <p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [NAMES]. I have also sent it to [NAMED PERSON] who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p> |
| 9 | <p>[DATE] <span style="float: right;">[SIGNED BY CORONER]</span></p>   |