IN THE WEST YORKSHIRE WESTERN CORONER'S COURT
IN THE MATTER OF:

The Inquests Touching the Death of Grahame Searby
A Regulation Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: **South West Yorkshire Partnership NHS Foundation Trust**
1	**CORONER** Martin Fleming HM Senior Coroner for West Yorkshire Western
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 20 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 2/8/17 I opened an inquest into the death of Grahame Searby who, at the date of his death was aged 59 years. The inquest was resumed and concluded on 15th May 2018 I found that the cause of death to be: - 1a. Hanging I arrived at the following narrative conclusion: - On 27th July 2017 Grahame Searby, who suffered from extreme anxiety and depression, was found hanging from a rope attached to a ceiling joist at the top of the stairs at his home address. It is found that he intended his death. At the time of his death he was under the supervision of the mental health services in the community, and although there was an opportunity to admit him to hospital, it remains unclear whether it would have made a difference to the outcome.

4	**CIRCUMSTANCES OF DEATH** Mr Searby had a history of suffering from extreme anxiety and depression for which he was under the auspices of his GP and MHS. When he failed to attend his medical review appointment on 27/7/17 as expected, his community Psychiatric Nurse made several unsuccessful attempts to contact him by phone before attending at his home address to find no response. This resulted in the attendance of the police in order to conduct a welfare check, and it was then that Mr Searby was to have died by hanging. At the inquest evidence was heard from Mr Searby's mental health team including [redacted] and [redacted] Before he died Mr Searby was admitted to A&E on 20/7/17 and 23/7/17 in a state of extreme anxiety when he asked to be voluntarily admitted for treatment to hospital. After risk assessment it was thought appropriate that he be placed under the care of the Home based treatment team.
5	**<u>CORONER'S CONCERNS</u>** During the evidence [redacted] and [redacted] informed me that at the time of Mr Searby's death, the mental health team did not have access to the system one database or EMIS for the purposes of referencing the GP's database. Although I was told that access via the system one data base is currently in operation, there is still no access to the appropriate date via EMIS The **MATTER OF CONCERN** is as follows. – • To review the existing operational systems and to consider the appropriateness of facilitating access via EMIS in order to improve the information gathering process.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that South West Yorkshire Partnership NHS Foundation Trust the has the power to take such action.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to: • [redacted] - daughter • [redacted] • [redacted] • Chief Coroner
9	**DATED this 23/5/18**