REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Berkshire Healthcare NHS Foundation Trust**.
1	**CORONER** I am Peter James Bedford, Senior Coroner, for the coroner area of Berkshire
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** I conducted an Inquest into the death of Miss Chandni Nigam that was heard at Reading Town Hall between the 27th and the 29th April 2015. The conclusion of the Inquest was in the terms of a Narrative Conclusion attached to this report.
4	**CIRCUMSTANCES OF THE DEATH** Miss Nigam was a nineteen year old young lady who first showed signs of depression aged thirteen in 2008. The symptoms became more acute she came under the care of the Mental Health Team in the form of both the Crisis Team and Community Mental Health Team. Her parents had arranged for her to be seen by private clinicians and subsequently the NHS Mental Health Team and there was a brief period of overlap of care. While expressing suicidal idealisation, Miss Nigam had never attempted serious self-harm. On the 4th February 2014 she was struck by a train at Twyford Railway Station.
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 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. – (1) During the course of her on-going care, Miss Nigam was being seen by private psychiatrist and psychologist. When she reverted to NHS Mental Health Team Care she still had on-going sessions with the private psychologist. There was an opportunity to gain history and input from the private clinicians as to Miss Nigam's history, previous treatment and what had been successful and less successful. No attempt to obtain that history or any input from the previous private clinicians appears to have been made. There was an opportunity to obtain helpful and effective historical information that may have assisted in the treatment of Miss Nigam by the Mental Health Team.

6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe your organisation has 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 Wednesday 8th July 2015. 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 family of Miss Nigam. You are 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	**Monday 11th May 2015** **Peter J. Bedford** **Senior Coroner for Berkshire**