REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Chief Executive Kent & Medway NHS & Social Care Partnership Trust
1	**CORONER** I am Patricia Harding, senior coroner for the coroner area of Mid Kent & Medway
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 4th June 2015 I commenced an investigation into the death of Joanna Bowring, 32 years. The investigation concluded at the end of the inquest on 26th January 2016. The conclusion of the inquest was that Joanna Bowring died on 1st June 2015 on the rail track at Boxley, Kent from injuries sustained as a result of being struck by a high speed train. She committed suicide.
4	**CIRCUMSTANCES OF THE DEATH** Joanna Bowring had been suffering with depression, paranoid delusions and suicidal thoughts. She was receiving support and treatment from the mental health team in the community. She had last been seen by the team on 28th May 2015 at which time her mental health was determined to have deteriorated and she had purchased rope from the internet for which she would not give a reason. She had no active suicidal thoughts at the time of the review and was not determined to meet the criteria for a hospital admission. On the 1st June 2015 she committed suicide. There was evidence of significant planning
5	**CORONER'S CONCERNS** 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. – (1) The patient and carer left an initial assessment conducted on 4th April 2015 without a clear understanding of the service available and without a care plan (2) Carers were not routinely included in the risk assessment process and their views about the patient and knowledge of the patient were not actively sought (3)Carers were not advised about any behaviours that might indicate an increased risk

	of suicide
6	**ACTION SHOULD BE TAKEN** In my opinion 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 25th March 2016. 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] parents, [redacted] brother 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	**27th January 2016** **[SIGNED BY CORONER]**