G A Short
Senior Coroner for Central Hampshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Southern Health NHS Foundation Trust**
1	**CORONER** I am G A Short, Senior Coroner for Central Hampshire
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 19/11/2015 I commenced an investigation into the death of Anna Mary Macfie Masson, aged 67. The investigation concluded at the end of the inquest on 14 March 2016. The conclusion of the inquest was Suicide
4	**CIRCUMSTANCES OF THE DEATH** I determined that Anna Masson was suffering from depression. On 17 November 2015 she went to Micheldever railway station and at about 09.42 she jumped into the path of a non-stopping fast train passing through the station. She died due to Multiple Injuries
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) I received the Trust's Root Cause Analysis Report relating to the treatment of routine referrals by general practitioners which disclosed a recently introduced screening pathway process. The evidence showed that screening potential service users is conducted by relatively junior members of staff and my concern is whether this process is robust enough to identify those who need urgent treatment. (2) It was unclear from the evidence given whether the screening pathway applied only to the local community mental health team or across all equivalent teams employed by the Trust. I consider that there should be a consistent practise in all teams.

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6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Southern Health 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, namely by 11 May 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 Person: [redacted]. I have also sent a copy of the report to [redacted] who I believe has a proper interest. 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	Dated 15 March 2016 Signature _____ Senior Coroner for Central Hampshire

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