	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Dr [redacted], President of the Royal College of Psychiatrists** **2. [redacted], Chief Executive of NHS England**
1	**CORONER** I am Caroline Topping assistant coroner, for the coroner area of Surrey.
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 25th February 2021 an investigation was commenced into the death of Cynthia Elizabeth Finlay. The investigation concluded at the end of the inquest on 12th April 2022. The conclusion of the inquest was suicide, the cause of death being suspension.
4	**CIRCUMSTANCES OF THE DEATH** **i.) Cynthia Elizabeth Finlay suffered from depression and had the onset of cognitive difficulties and personality traits which made her liable to be impulsive. It became impossible for her family to care for her.** **ii.) On the 4th February 2021 she took an overdose and was admitted to hospital then discharged home on the 6th February 2021. She was living alone.** **iii.) On the 8th February 2021 she was assessed by a community psychiatric nurse from the community mental health team who set up a further assessment for the following morning with a psychiatrist to consider whether a Mental Health Act assessment was warranted. One of her daughter's attended the assessment.** **iv.) On the 9th February 2021 she was assessed by the psychiatrist who did not accurately assess the risk of harm she posed to herself through her impulsivity and did not immediately initiate a Mental Health Act assessment.** **v.) Her daughter, who was present, made it clear she could not stay with her Mother. No adequate plan was put in place to safeguard Ms Finlay.** **vi.) Following the assessment, she was left alone. She [redacted] in the garden at her home. She asphyxiated. She had written notes indicating an intention to take her own life.**

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 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) Expert evidence was received from a Consultant Psychiatrist who indicated that there is no protocol in place which governs what steps should be taken to safeguard people who are awaiting Mental Health Act assessments and may be alone and at risk in the community whilst the assessment is set up.
6	**ACTION SHOULD BE TAKEN** 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	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 6th July 2022. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting outthe 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] Surrey and Border Partnership NHS Foundation Trust Surrey County Council Adult Social Care I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**11th May 2022, Caroline Topping**