HM Coroner's Court A Block – Ground Floor County Hall Victoria Road Chelmsford CM1 1QH



HM Senior Coroner for Essex

Telephone: 0333 013 5000 coroner@essex.gov.uk

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This form is to be used after an inquest.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	North Essex Partnership NHS Foundation Trust
1	CORONER
	I am Caroline Beasley-Murray, Senior Coroner, for the coroner area of Essex
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 21 January 2013 I commenced an investigation into the death of Marion Joanne Turner. The investigation concluded at the end of the inquest on 23 June 2014. The conclusion of the inquest was that Ms Turner killed herself whilst suffering from a diagnosed mental illness. The cause of death was 1a) Hanging.
4	CIRCUMSTANCES OF THE DEATH
	Marion Joanne Turner, a 40 year old lady was found hanging at her home address on 18 January 2013. She had a history of mental illness, alcoholism, self-harm and relationship difficulties. She had had inpatient treatment at times and at the time of her death she was under the care of the community mental health team.
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) Evidence was given that the day before Ms Turner's death, her solicitor, as a result of concerns about her mental health, had telephoned into the mental health trust office and left a message for Ms Turner's CPN. This message remained on a slip of paper, unread, in a pigeon hole until sometime the next day. **ACTION SHOULD BE TAKEN** 6 In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action. YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 19th August 2014, 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. **COPIES and PUBLICATION** 8 I have sent a copy of my report to the Chief Coroner and to the following Interested Persons -John Fowlers, solicitors for the family The CQC 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.

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Caroline Beasley-Murray

25 June 2014