IN THE SURREY CORONER'S COURT IN THE MATTER OF:

The Inquests Touching the Death of Julia Ann Clarke Hayward A Regulation 28 Report – Action to Prevent Future Deaths

THIS REPORT IS BEING SENT TO:

 The Rt Hon Jeremy Hunt MP, Secretary of State for the Department of Health

1 CORONER

Simon Wickens HM Area Coroner for Surrey

2 | CORONER'S LEGAL POWERS

I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.

3 INVESTIGATION and INQUEST

The inquest into the death of **Mrs Julia Ann Clarke Hayward** was opened on the 29th May 2014 and was resumed on the 10th August 2015. It was concluded on 11th August 2015.

The cause of death was:

1a – Multiple Injuries.

The Narrative conclusion was; On the 23rd May 2014 at the railway lines at St Johns, Woking Julia Ann Hayward died of multiple injuries sustained after she intentionally placed herself in the path of an oncoming train whilst suffering from mental illness. Her intention at the time was unclear.

4 | CIRCUMSTANCES OF THE DEATH

On the 21st May 2015 Mrs Hayward ran out in front of a lorry. She was not injured but was detained and assessed under the Mental Health Act 1983. Following the assessment and discussion with her husband, Mrs Hayward was discharged home.

On the 22nd May 2014 Mrs Hayward was visited at home by the Home Treatment Team.

On the 23rd May 2014 after her husband left the home address, Mrs Hayward travelled to the railway line where she accessed the tracks and placed herself in front of a train, which led to her death.

5 | CORONER'S CONCERNS

During the course of the inquest the evidence revealed that when a decision was made to discharge a patient home and into the care of a family member, following a mental health assessment. The Care Plan was agreed orally and not documented for the family member. Consequently, issues arose as to what was expected/anticipated of the family member under the Care Plan and what was understood by that family member as being their obligations.

The **MATTER OF CONCERN** is:

Agreement of a Care Plan

Consideration should be given to ensuring that following a MHA 1983 assessment where a discharge is decided upon and care plan is agreed (in particular if it places any obligations upon a relative/family member) such plan is clearly documented and a copy of the plan is given to that person/persons as well as the patient discharged.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.

8 COPIES

I have sent a copy of this report to the following:

- 1. The Rt Hon Jeremy Hunt MP, Secretary of State for the Department of Health.
- 2. The Interested Persons in the Inquest:
 - a. b.
- 3. The Chief Coroner

Signed:

Simon Wickens

DATED this 11th August 2015