




G A Short
Senior Coroner for Central Hampshire

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| | <p style="text-align: center;">REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p style="text-align: center;">THIS REPORT IS BEING SENT TO: Southern Health NHS Foundation Trust</p> |
| 1 | <p>CORONER</p> <p>I am Grahame Antony Short, Senior Coroner for Central Hampshire</p> |
| 2 | <p>CORONER'S LEGAL POWERS</p> <p>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</p> |
| 3 | <p>INVESTIGATION and INQUEST</p> <p>On 28/05/2015 I commenced an investigation into the death of Louise Dawn Locke, aged 44 . The investigation concluded at the end of the inquest on 26 January 2016. The conclusion of the inquest was Suicide. Between 13.18 and 14.55 on 27 May 2015 Louise Locke hanged herself at her home in Milland Road Winchester Cause of death: 1a) Asphyxia 1b) Hanging</p> |
| 4 | <p>CIRCUMSTANCES OF THE DEATH</p> <p>Louise Locke was a vulnerable adult suffering from undiagnosed mental problems associated with alcohol dependency who had interaction with multiple agencies in the last 7 months of her life. She sought help on numerous occasions but was reluctant to engage properly with the substance misuse service. At the time of her death she had been discharged from the Community Mental Health Service, but information was available to other individual agencies which would have alerted those responsible of her high risk of suicide if the overall picture had been recognised, so that she could be given appropriate support.</p> |
| 5 | <p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>(1) The Community Mental Health Service discharged Louise Locke prematurely and without carrying out a proper risk assessment or offering her adequate support (2) There was no adequate system in place to collate and assess information from other agencies such that her risk profile could be reviewed and appropriate support offered (3) The systems already in place in some parts of Hampshire for a multi-agency approach to high risk individuals do not apply in Winchester and so opportunities to recognise these people are being missed. There should be a consistent approach by Southern Health to suicide prevention across all of the areas it serves.</p> |
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| 6 | <p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you Southern Health have the power to take such action.</p> |
| 7 | <p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 29 March 2016. I, the coroner, may extend the period.</p> <p>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.</p> |
| 8 | <p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [REDACTED] and HAMPSHIRE COUNTY COUNCIL. I have also sent it to [REDACTED] who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p> |
| 9 | <p>Dated 29 January 2016</p> <p>Signature  _____ Senior Coroner for Central Hampshire</p> |