IN THE SURREY CORONER'S COURT

IN THE MATTER OF:

The Inquest Touching the Death of

A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO:
	 Domestic Abuse Management Board Surrey Police
1	CORONER
	Caroline Topping HM Assistant Coroner, for the County 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
	An inquest into the death of second was opened on 6 th December 2017, resumed on the 12 th October 2020 and concluded on the 14 th October 2020. I concluded with a narrative conclusion that: died on the 29th November 2017 at . She had tied a ligature around her neck and died by hanging. She had drunk considerable amounts of alcohol and taken cocaine. It is not possible to determine whether she intended to kill herself.

	1a. Hanging
4	CIRCUMSTANCES OF THE DEATH
	died at her home address having consumed a considerable quantity of alcohol and cocaine. She tied a ligature around her neck and died by hanging. It was not clear if this was a cry for attention or help and whether she thought she might be found in time.
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. –
	The evidence showed that:
	The evidence showed that:
	 manufacture was being treated for depression by her general practitioner. She was prescribed anti-depressant medication. She had last been reviewed in February
	2017. She was not open to secondary mental health provision.
	 was the subject of a MARAC referral organised by the Surrey Police on the 14th June 2017 in respect of allegations of domestic violence and coercive control which make made relating to her partner.
	 general practitioner was not invited to contribute to the MARAC meetings held in July and August 2017. General Practitioners are not routinely
	invited to MARAC meetings.4. The risks and the planned safeguarding measures identified by the MARAC
	were not communicated to the general practitioner.5. The general practitioner responsible for treating mental health was not
	made aware of the allegations of domestic abuse and coercion that made had made.
	6. children were removed from her care in the second and she was
	then involved in care proceedings. Her general practitioner was not made aware of this although it would have been a further significant stressor so far as her
	mental health was concerned.
6	ACTION SHOULD BE TAKEN
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	In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 5 th January 2021. 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 Persons; and Heathcote Medical Centre.
	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	Signed:
	Caroline Topping
	Dated this 9 th November 2020.