Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Secretary of State for Health** **2 Chief Executive Officer, Hampshire and Isle of Wight Healthcare Foundation NHS Trust**
1	**CORONER** I am Henry CHARLES, HM Assistant Coroner for the coroner area of Hampshire, Portsmouth and Southampton
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 28 November 2023 I commenced an investigation into the death of Samantha Kate YOUNG aged 49. The inquest was concluded on 5th June 2025. The medical cause of death was 1a Hanging.
4	**CIRCUMSTANCES OF THE DEATH** A narrative conclusion was recorded at Box 4 of the Record of Inquest On 20th November 2023 Samantha Young died at her home, [redacted]. Sadly, she had intentionally taken her own life by hanging herself with a ligature. The background is that Samantha Young had struggled for a number of years with her mental health. She had, impressively, managed to control an alcohol addiction and had indeed stopped taking alcohol. At the time of her death she was under very great stress following marriage breakdown and relocation. She had attempted suicide before. She was under the care of the CMHT, she had been and continued to access private medical care, which was undoubtedly beneficial. She had received substantial and effective family support. Her condition had deteriorated in early November 2023. It is clear that she had made many attempts – successfully so - to access medical treatment, and statutory service support right to the end whilst battling her mental health issues. She had done all she could to help herself and remain in the life of her daughter.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) A. Assessment of the risk that a patient poses to themselves or others is clearly a

	cornerstone of the work of an NHS Trust dealing with mental health. At the material time there was a lack of any training as to compilation of risk assessments. I was informed by a senior manager of Hampshire and Isle of Wight Healthcare NHS Trust that with the translation of Southern Health NHS Foundation Trust into the new Hampshire and Isle of Wight Healthcare NHS Foundation Trust that issue of training is being addressed. However it emerged at the inquest that there do not appear to be any firm plans to train agency staff. Agency staff form a significant percentage of frontline staff. Hampshire and Isle of Wight Healthcare NHS Trust should review its provision of training for agency staff, in particular in respect of risk assessments. B. Wider family and friends of the deceased perspective were not contacted.. A patient's family and friends are clearly an invaluable resource for learning more about a patient's mental health and specifically risk to life, the support available to the patient and the potential for synergistic support with the NHS Trust. This PFD is not the first time that the issue has been raised with Southern Health NHS Foundation Trust: in 2023 the Senior Coroner for Hampshire, Portsmouth and Southampton issued a PFD on similar grounds arising out of the inquest into the death of Kirsty Taylor. The Senior Coroner observed in the PFD that "I remain concerned (as it is a matter I have raised on many occasions at inquest and again as a result of the experiences of the family in this case), that communication with the families of patients with mental health difficulties is still not being effectively achieved. Nor are such families being sufficiently, effectively and meaningfully listened to or understood when they voice concerns, based on their experience of the patient outside of a treatment or assessment environment. Consequently, I am concerned that such matters are not being reflected sufficiently or frequently enough in the onward treatment of those patients or in the clinical curiosity afforded to their conditions." Moreover, in 2021 a report commissioned by NHS England into Southern Health Foundation Trust similarly reported on shortfall in communication with families. Hampshire and Isle of Wight Healthcare NHS Trust should review guidelines and procedures concerning communication with family and friends of patients with mental health difficulties by its permanent and agency staff, and monitoring of whether such communication has taken place.
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 September 18, 2025. 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 **the family of Samantha Young, Hampshire County Council and** [redacted] 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 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 by the Chief Coroner.
9	**Dated: 25/07/2025**  **Henry CHARLES** **HM Assistant Coroner for** **Hampshire, Portsmouth and Southampton**