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 Southern Health Foundation Trust (Legal)**
1	**CORONER** I am Nicholas WALKER, HM Area 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 01 March 2024 I commenced an investigation into the death of Ethel Mitchell ROBERTSON aged 79. The investigation concluded at the end of the inquest on 20 October 2025. The conclusion of the inquest was that: Ethel died from the consequences of an intentional overdose [redacted] which she took to end her life. A conclusion of suicide was reached.
4	**CIRCUMSTANCES OF THE DEATH** Ethel had a long history of depression and anxiety which was made worse by chronic alcohol consumption and she had, since 2014, taken intentional drug overdoses on eleven occasions. Her care was managed by her GP and the Older Persons Mental Health Service [OPMH], part of NHS Southern Health NHS Foundation Trust. Ethel would attend hospital emergency department [ED], as she had a few weeks before her death when she presented at Queen Alexandra Hospital in Portsmouth after an apparent accident. She was found deceased at home on 18th February 2024.
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) An Area Matron at the Older People's Mental Health Service [OPMH] gave evidence that the service is not routinely informed when one of their patients is admitted to or discharged from ED. If the presentation at the hospital was for a mental health related issue, then the OPMH team is likely notified as there will be contact with the psychiatric liaison service in the hospital. However, if the presentation is for something not related to mental health, the OPMH will not be notified as clinicians within the ED do not have access to the computer systems operated by service providers in the community. I am concerned that OPMH will not know if one of their patients has had a physical health

	crisis which could precipitate a decline in their mental health or has presented with something that those not familiar with the patient might fail to appreciate is linked to their metal health. I am concerned that this will have serious implications for patient safety and could delay appropriate follow-up, risk management and decision-making. It also places an added pressure on those in primary care to have systems in place to alert the community teams when they receive discharge documentation from ED.
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 January 12, 2026. 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 [redacted] I have also sent it to who may find it useful or of interest. 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: 17/11/2025** [redacted] **Nicholas WALKER** **HM Area Coroner for** **Hampshire, Portsmouth and Southampton**