



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: [REDACTED], Chief Executive, NHS England
1	CORONER I am Joseph TURNER, Area Coroner for the coroner area of West Sussex, Brighton and Hove
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 23 rd January 2025 I commenced an investigation into the death of Joanna Chamberlain. The investigation concluded at the end of the inquest on 7 November 2025. The conclusion of the inquest was that on 23 rd January 2025, Joanna Chamberlain was found suspended from a ligature at her home address in Hassocks, West Sussex. Emergency services attended but, despite CPR, Joanna was sadly declared to be deceased at the scene. Joanna had experienced suicidal thoughts for many months and had made several previous attempts, but had not been assessed as high risk, in part because no input was sought or received from her family. Her significant physical health conditions more than minimally contributed to her poor mental health. She took her own life also in part because her overwhelming and longstanding mental health issues had never been fully or successfully treated.
4	CIRCUMSTANCES OF THE DEATH The day before her death, Joanna attended clifftops near her home with the intention of jumping but had drawn back and contacted her GP as well as attend a pre-planned assessment with a locum clinical psychiatrist at her local mental health assessment and treatment service unit. The GP contacted the mental health team to ensure Joanna was seen urgently. Notwithstanding the events of earlier in the day, which followed a recent overdose and other incidents of self-harm involving makeshift ligatures around her neck, the assessment was that Joanna was at moderate risk. The assessment was made largely on Joanna's immediate presentation, with reference to care notes but no other 3 rd party (e.g. GP) or family input. Whilst a period in a 24 hour 'Haven' crisis facility was considered, the plan agreed with and by Joanna was for her to return home, where the presence of her husband and son were powerful protective factors, and receive daily input and support from the Crisis Resolution Home Treatment Team (CRHTT). Joanna had previously been in their care. Joanna did not want to enter a unit as a voluntary patient and nor was this deemed necessary. Joanna duly returned home, to the great surprise and concern of her husband who had strongly expected her to have been admitted to residential care and treatment. After lengthy discussion with Joanna, he was reconciled to the immediate plan but both he and Joanna felt and hoped the team's visit the next morning may initiate the process for her to be a voluntary in-patient, despite previous reluctance. Joanna had withdrawn consent for her confidentiality to be waived as regards her husband

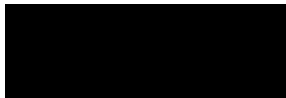


	2 days earlier, for fear of her condition and the involvement of mental health services adding to his stress and burden. Even during the periods where she had given consent, however, at no time had he been consulted or included in her care plan. Moreover, at no time had he been informed that, outside and separate to the confidentiality of Joanna's care, he could have voluntarily provided information and input to the teams involved. Partly due to the financial pressures on the family occasioned by Joanna's incapacity for work due to her physical and mental conditions, and in the hope and expectation that the CRHTT would attend, further assess Joanna and help, her husband left for work early the following morning, before the planned attendance of the CRHTT at 10 am. Sadly, this removed a powerful protective factor and Joanna took her own life before the team attended at her address.
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: Whilst I am keenly aware that it is not for Coroners to investigate matters of national public policy or resource, there appears to be a local and national gap in the provision of safe and supportive spaces, where clinical help and care can be given to mental health patients who may not be in immediate crisis yet who would benefit from more support than can be given by home treatment teams. Or whose risk assessment suggests may benefit when protective factors change or are temporarily unavailable at certain times of the day or night. Equally, whilst I recognise the importance and value in clinicians rapidly assessing a patient's risk of self-harm, using their individual professional judgement, and forming an immediate care and safety plan, there is a potential need for clearer national guidance on, direction to and protocols for clinicians to proactively seek and include the views and input of family members, or others (e.g. GP), reinforcing the triangle of care, and especially where the delivery or assurance of a care and safety plan depends on them. This appears even more necessary where such individuals themselves are a key protective factor.
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 02, 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], Chief Executive, Sussex Partnership NHS Foundation Trust 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.



Coroner Service

West Sussex, Brighton & Hove

	The Chief Coroner may publish either or both in a complete or redacted or summary form. They may send a copy of this report to any person who they believe 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: 10/11/2025  Joseph TURNER Area Coroner for West Sussex, Brighton and Hove