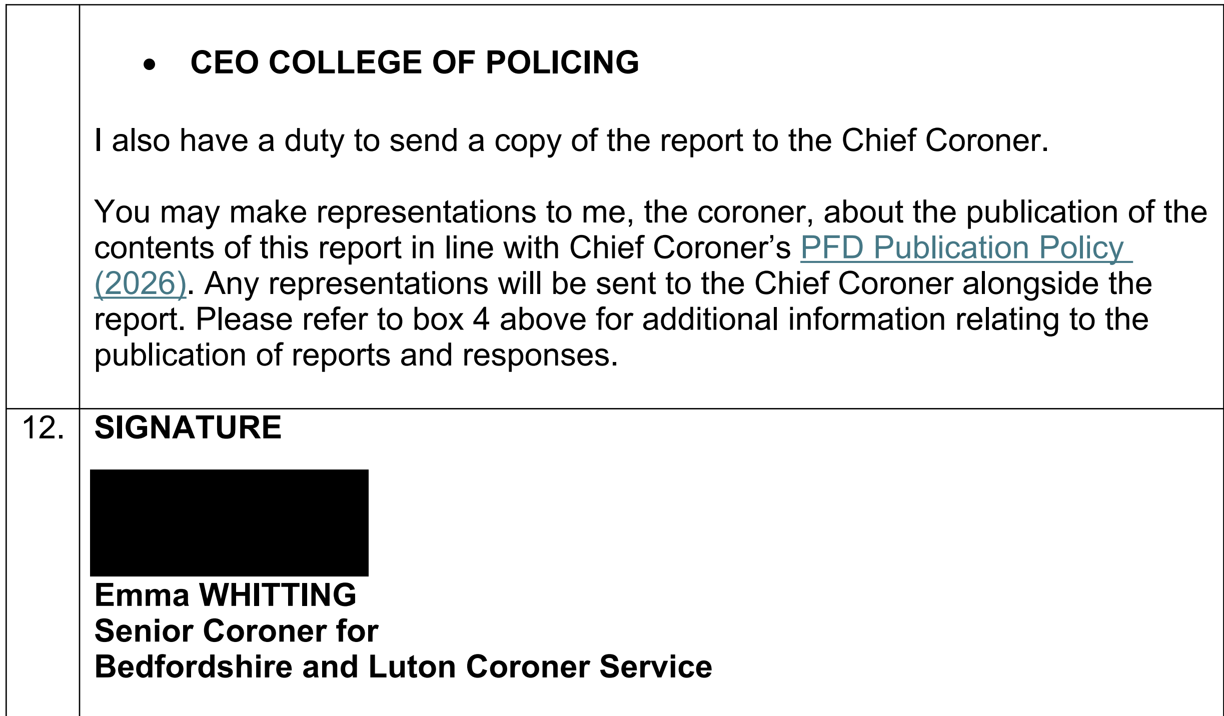
REPORT TO PREVENT FUTURE DEATHS REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013 Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).	
1.	**CORONER** I am Emma WHITTING, Senior Coroner, for the coroner area of Bedfordshire and Luton Coroner Service.
2.	**DATE OF REPORT** 04 May 2026
3.	**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.
4.	**THIS REPORT IS BEING SENT TO** 1. Chief Constable Trevor RODENHURST 2. The Rt Hon Shabana Mahmood MP You are under a duty to respond to this report within 56 days of the date of this report, namely by June 29, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6.	**SUMMARY OF CORONER'S CONCERN**

	As highlighted by the DARDR/SAR investigation, all relevant agencies who had contact with the Deceased had 'worked in silo' rather than holistically and, whilst Police responded in line with good practice to the criminal allegations made, this did not subdue the Deceased's fear of further domestic abuse.
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** On 24 May 2024 I commenced an investigation into the death of Suseel RANA aged 36. The investigation concluded at the end of the inquest on 15 April 2026. The conclusion of the inquest was that Suseel Rana died from **Suicide.**
9.	**CIRCUMSTANCES OF DEATH** The Deceased suffered from a number of physical and mental health conditions whilst also being the main carer for her mother. She had been under the care of the local mental health teams since 2018 and had been diagnosed with bipolar affective disorder and generalised anxiety. She also had a history of deliberate overdose. She was being treated via the Care Programme Approach but had not been allocated a Care-Coordinator only a Mental Health Support Worker, She had reported a number of domestic abuse incidents since 2021 and, on 20 April 2024, her ex-partner was arrested and bailed with protective conditions following allegations that he had made threats to kill her and had caused damage at her home. Although she decided not to support the criminal investigation, on 26 April 2024, she made an application under 'Clare's Law' in respect of that ex-partner. On 27th April 2024, she contacted the Mental Health Crisis Team stating that she was feeling overwhelmed with anxiety, suffering panic attacks, and felt unable to leave her house because her ex-partner was living nearby. She also verbalised suicidal thoughts but denied having any plans or intent to act upon them. On 2 May 2024, she again reported to her Mental Health Support Worker that she was not leaving her house on her own as she was scared about the threatening behaviour of her ex-partner and wanted to move from the area. On 13 May 2024, she was informed by the Victim Engagement Officer by telephone that there were no grounds for her 'Clare's Law' application to be continued during which conversation she confirmed that she was struggling with her mental health. Police ensured that she was being seen by mental health services and she was reviewed by her psychiatrist that same day during which consultation she reported that 'her brain was ruminating', and she felt like she was in a 'fight and flight' situation, reporting both elevated anxiety and being bothered about a long-standing personal relationship. Although it was clear that she was continuing to fear becoming victim to domestic abuse, no safeguarding referral was made and opportunities for relevant statutory agencies to use the information they had to take practical steps to help her manage her anxiety, alongside her physical health issues and caring responsibilities, including using advocacy support, were not taken. She was last seen and heard from on the evening of 20 May

	2024 and did not emerge from her bedroom on 21 May 2024. Although her mother had carers to the house that day, they did not enter her room and it was not until her friend arrived, at around 18.00 hours, that she was found to be in cardiac arrest on her bedroom floor. Paramedics attended and attempted resuscitation but confirmed her death at 18.53 hours. Post-mortem examination revealed she had ingested [redacted] in excess prior to death and a handwritten note found at the scene confirmed an intention to take her own life.
10.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: 1) In seeking some reassurance as to her safety, the Deceased had made a Clare's Law application under the Domestic Violence Disclosure Scheme (DVDS) prior to her death; however, this was had not been progressed by Police. 2) The reason for the lack of progression of the Deceased's Clare's Law application appear to have been based on a misunderstanding by the investigating officer that Clare's Law could not be used in respect of a previous partner. 3) Neither the investigating officer nor the supervising officer appeared to recognise that the Deceased's level of anxiety, as indicated by her Clare's Law application, required further safety planning. 4) The lack of progression of the Deceased's Clare's Law application to the actual decision making stage meant that the steps envisaged by the DVDS Guidance, which include a referral to a multi-agency forum (as illustrated by Figure 1 on page 8 of the Guidance), were not taken. Had such steps been taken, it is likely that the Deceased would have been more supported. 5) Whilst paragraph 76 of the DVDS Guidance states: "*The police may make the decision not to progress the disclosure following the completion of intelligence checks*" - it is not currently clear whether the intention of the Guidance is for Police still to proceed to the decision making stage as to whether to make any disclosure or not (which would involve the multi-agency referral referenced above) or, whether, in that situation no further steps at all are required (as occurred in respect of the Deceased's application).
11.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: *[please do not use individual's names, but instead roles/titles]*



	• **CEO COLLEGE OF POLICING** I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner’s PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	**SIGNATURE** **Emma WHITTING** **Senior Coroner for** **Bedfordshire and Luton Coroner Service**