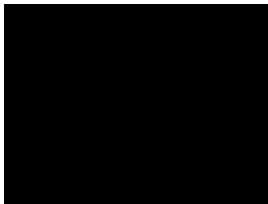


**REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS
2013**

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 Nicholas Walker, Area Coroner for the Coroner area of Hampshire, Portsmouth and Southampton
2.	DATE OF REPORT 28 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. Secretary of State for Health 2. Chief Executive Officer, Hampshire and Isle of Wight Healthcare Foundation NHS Trust You are under a duty to respond to this report within 56 days of the date of this report, namely by July 23, 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

	I am concerned that the Trust routinely is unable to secure acute psychiatric beds for vulnerable patients who are waiting for an assessment under the Mental Health Act.
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 06 September 2024 I commenced an investigation into the death of Jonathan Edward DOUGHTY aged 43. The investigation concluded at the end of the inquest on 24 April 2026. I concluded the inquest identifying a number of failings that possibly and probably contributed to the death of the deceased, some of which, in combination, amounted to neglect.
9.	CIRCUMSTANCES OF DEATH Jonathan Edward Doughty died in Southampton General Hospital on 28th August 2024, two days after he was found hanging at his home in Eastleigh, Hampshire. He died as a consequence of the hanging. The deceased's mental state significantly deteriorated during 2024 and on 23rd August 2024 it was considered that he should be assessed under the Mental Health Act 1983 with a view to an involuntary admission to a psychiatric hospital because he was refusing treatment and medication, harming himself, was actively suicidal and showing signs of psychosis. The assessment could not take place as an acute bed was not available and he had to be kept safe in the community until a bed was found. The medical professionals who ordered the assessment were concerned that if the deceased knew of the plan to assess him, and its likely consequences, he would be at risk of harming himself and so planned for him not to be told about it for his own protection. Over the next two days, a nurse from the mental health crisis team visited the deceased and told him in robust terms of the plan to assess him under the Mental Health Act. I found that the deceased was greatly affected by this unnecessary and risky disclosure and was made frightened and anxious by it, and that it more than minimally contributed to the deceased taking his life the day following the visit by the crisis team nurse.
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:

	I heard evidence that Hampshire and Isle of Wight Healthcare Trust were routinely unable to secure acute psychiatric beds for patients such as the deceased who lacked capacity and posed a risk to themselves. In such circumstances, a Mental Health Act Assessment cannot take place until a bed is available and the risk has to be managed in the community, often by family members or crisis team nurses who might only visit for a short time. Patients are left vulnerable and I am concerned that there is a risk that future deaths will occur unless action is taken.
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: <i>[please do not use individual's names, but instead roles/titles]</i> • Spouse 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  Nicholas WALKER HM Area Coroner for Hampshire, Portsmouth and Southampton