REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: EPUT and NHS England**
1	**CORONER** I am Area Coroner for Essex
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** On 5th August 2021 I commenced and concluded an inquest into the death of Steven Antonio Regoli
4	**CIRCUMSTANCES OF THE DEATH** Steven Antonio Regoli died on the 26th June 2020 died at a Lineside location adjacent to Gipsy Lane due to Multiple Injuries following a collision with a train, with underlying Adjustment Disorder, Mixed Anxiety and Depressive Disorder. He was known to EPUT At approx. 11.20 hours on the 26th June 2020 the driver of the [redacted] Cambs North to Liverpool Street was coming around the track curve, when he saw a man stood under the bridge next to Gypsy Lane. As soon as he saw the train, this male pushed off the wall and headed into the path of the train. The driver was travelling at 70 mph and was unable to stop. Mr Regoli was identified by his fingerprints. EPUT prepared a 7-day report, which was being used during the COVID Pandemic. This report set out the detail of the issues that Steven Regoli had, he was predominantly living with his elderly parents who had consistently in evidence at the inquest said that they tried to get inpatient care for their son as they were struggling to cope, describing having to sleep by the front door to stop him leaving, where he would then take illicit drugs and overdose. The report set out that he was admitted to Peter Bruff Ward following an overdose and was discharged 7 days later and within 3 days had taken [redacted] tablets, following this and the next day it was determined that he should be discharged back to his mother's address. On the 18th June 2020- 8 days before Steven died, he told his Care Coordinator he felt like ending his own, which he then subsequently did.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest, it revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – In the 7 day report it set out numerous opportunities for Steven and his family to have more appropriate help to include inpatient stay for Steven given his history of overdoses

	and his worsening anxiety and depression. He had spoken about taking himself down to the railway line on other occasions as he used to work near there. Steven, due to his anxiety and with COVID restrictions was unable to engage but he struggled engaging with people before these restrictions. During the inquest, there were clear signs that Steven needed more in depth help as did his family, but due to him not engaging, which was a major part of his symptoms he was never given the pathway or help he needed and there were no systems in place for this to happen. There needs to be systems in place where people who do not engage are not left with family only to care for them.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you 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 12th October 2021 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 who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. 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	**Date. 17th August 2021** **Name Michelle Brown** **Area Coroner Essex**