Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], **CEO, Govia Thameslink Railway Ltd,** 3rd Floor, 41-51 Grey Street, Newcastle upon Tyne, NE1 6EE 2. [redacted], **CE, Network Rail,** 1 Eversholt St, London NW1 2DN
1	**CORONER** I am Robert SIMPSON, Assistant Coroner for the coroner area of West Sussex Coroners Service
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 15 April 2021 I commenced an investigation into the death of Kaja Weronika SPIEWAK aged 18. The investigation concluded at the end of the inquest on 24 November 2021. The conclusion of the inquest was that: On the 7th April 2021 Kaja Weronika Spiewak died after deliberately [redacted]. She suffered from schizoaffective disorder and was under the care and treatment of mental health services.
4	**CIRCUMSTANCES OF THE DEATH** On the 7th April 2021 an onboard supervisor (OBS) for Govia Thameslink Railway Ltd noticed Kaja on Barnham Station at about 8.00am. The same OBS noticed Kaja boarding her train at Barnham station at 11.05am. Kaja got off at another station but the OBS was concerned about her welfare. The OBS invited Kaja to get back onto the train and then contacted the Govia Thameslink Railway control room raising her concerns about Kaja's vulnerability. The OBS did not report the concerns to the police and the Govia Thameslink Railway witnesses gave evidence that this would have been the recommended course of action. The Govia Thameslink Railway control room staff agreed that the OBS would hand Kaja over to the station staff at Havant train station. The control room staff then made contact with Brighton train station (as Kaja's reported destination), Havant station and conductors on a number of trains. After Kaja had left Havant station the control room staff were not able to ascertain where she had gone. By 12.04pm the control room

	staff had been informed that Kaja was not on the expected train. No further actions were recorded as being taken by control room staff until 1.40pm. Kaja had actually arrived at Southbourne Station by 11.50am and remained on the platform until approximately 12.20pm. She then [redacted] Kaja was declared deceased at 1.07pm.
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: (1) I heard evidence from the Suicide Prevention Manager for Govia Thameslink Railway Ltd that training on dealing with vulnerable persons was not mandatory for frontline staff. In fact only 583 out of 7,500 staff had attended a course run by the Samaritans entitled Managing Suicidal Contacts, 40% had completed some e-learning and an unknown number had completed an internal course. In addition refresher training on this issue was an aspiration only and had not been rolled out by Govia Thameslink Railway Ltd. I also heard evidence that the Suicide Prevention Manager for Govia Thameslink Railway Ltd did not have any input into the training for their team based in the joint control room. I am therefore concerned that those members of staff most likely to have contact with vulnerable or suicidal persons, as well as those responsible for assisting frontline staff, are not all properly trained to deal with the situation in the best possible way. (2) I heard evidence that Govia Thameslink Railway Ltd staff control room staff relied upon a protocol entitled 'Person ill on a train' when a vulnerable person was reported to them. The witness responsible for the Govia Thameslink Railway control room team accepted that this was not an appropriate document to rely upon as it made no mention of vulnerable persons. I am therefore concerned that the control room staff do not have the appropriate information to assist their colleagues and to arrange an appropriate response when a 'concern for welfare' report is made to them. (3) I heard evidence that the Govia Thameslink Railway Ltd control room staff did not log all actions taken after the concern for welfare report. I am concerned that it is not possible to assess whether all reasonable and appropriate actions were taken by the control room staff and whether individuals or teams have further training needs.

	(4) The Govia Thameslink Railway Ltd control room staff did not contact British Transport Police, 999 nor share the information about this 'concern for welfare' report with Network Rail despite having a joint control room. I heard evidence that there was no written protocol covering when Govia Thameslink Railway Ltd staff should share a 'concern for welfare' report with Network Rail staff in the shared control room. I am concerned that there is not appropriate information sharing and reporting to other agencies, including British Transport Police, when a 'concern for welfare' is raised.
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 27, 2022. 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: The Family of Kaja Spiewak British Transport Police and to the Local Safeguarding Board (where the deceased was 18). 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: 01/12/2021**

Robert SIMPSON
Assistant Coroner for
West Sussex Coroners Service