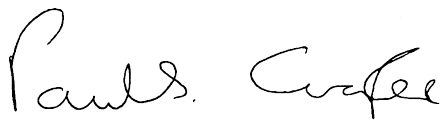
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Vine Street Sugery, Grantham** **2 LPFT Legal Services** **3 Legal Services Lincolnshire**
1	**CORONER** I am Paul COOPER, HM Assistant Coroner for the coroner area of Lincolnshire
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 01 March 2021 I commenced an investigation into the death of Emma Jane SIMKIN aged 24. The investigation concluded at the end of the inquest on 11 October 2022. The conclusion of the inquest was that: The deceased died on 20th February 2021 at Railway Lineside, Spitalgate Hill, Grantham by standing in front of a freight train and receiving non-survivable injuries.
4	**CIRCUMSTANCES OF THE DEATH** Incident was initially referred to the Coroner by way of EMAS Diagnosis of Death form then later by BTP Police. [redacted] This matter relates to the death of a 24 old female found on the railway line near Grantham having been struck by a freight train. Deceased was single having never married nor had children. She is survived by her parents and sister from whom she had been estranged for 2 years. Deceased's birth name is Emma Jane SIMKIN but at some point over the last 2 years changed it to Emilie Zukiard AFFIN but all her medical records are in her birth name. She lived in a multi occupancy house at the address stated. Medical background/history: long term mental health issues and was under the Mental Health Team with Paranoia and Bipolar Disorder. Medications: Lithium. Routine bloods taken on 11/12/20. Last contact with GP by telephone 14/12/20. No significant medical issues known. Working hypothesis at this moment in time is that in the early hours of 20/02/21 deceased had been in the Aldi car park, which is directly above the point of impact. [redacted] and was struck by a freight train. Reported by train driver who contacted his control stating that he had struck something. There is no CCTV at the point of access to the railway lines. Substantial amount of property recovered from scene including driving licence and notes. All currently being reviewed. Driving Licence, found on railway tracks and near perceived point of impact, in the name of Emilie Zukiaro AFFIN b. 16/03/1996. Additionally a bag with matching identification located in nearby Aldi car park. Some notes relate to intimating suicide and mental health issues have been recovered and which are thought to relate to the deceased. Death confirmed at scene by Paramedics at 0342 hrs. BTP officers attended scene. Body

	badly disrupted. ID confirmed by photo ID found at scene and by fingerprints. NOK (parents) [redacted], have been traced and informed. [redacted] has also spoken to them at length. BTP continuing investigation. Standard PM required to establish and confirm cause of death. Samples to be taken for toxicology to check for alcohol and drugs/medications. DS 01/03/21 - PM carried out at QMC on 26/02/21 by [redacted]. Cause of death; 1a Multiple Traumatic Injuries subject to toxicology. NOK - father and BTP updated. Body released. Please can an Inquest be opened and adjourned in relation to this matter. Interims to be sent to the deceased's father; [redacted] - address on wpc contact tab Burial Order to be sent to Sun Rising Funerals Warwickshire. Please write to the following to request reports and statements: GP re deceased's medical background and history, LPFT Mental Health Services re engagement with their services Addaction - We Area With You to establish if deceased had any dealings with them. All other reports and statements are in hand. DS 06/04/21 - Toxicology and PM reports received. NOK updated. Copies of reports sent to BTP ([redacted] Toxicology - A low level of ethanol was detected which may have resulted from post mortem changes. No other significant toxicological findings. The liver tissue sample was unsuitable for lithium analysis. PM result: 1a - Multiple Traumatic Injuries 1b - Collision with train. DS
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: (brief summary of matters of concern) Families are repeatedly advising their perception is that loved ones are successfully "masking" their mental illnesses in front of professionals who are perceived to accept at face value what they are told rather than looking at other primary evidence more often than not from the families themselves. which in turn leads the families to believe they are being ignored and lives lost. Can you reassure me that policies are in place that focus upon how to identify "masking" and adequate training to the appropriate professionals is up to date and consider if policies are in need of review.
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 December 06, 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

	Peter Richard SIMKIN I have also sent it to who may find it useful or of interest. 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: 12/10/2022**  **Paul COOPER** **HM Assistant Coroner for** **Lincolnshire**