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** [redacted] **Highways England** **Bridge House** **1 Walnut Tree Close** **Guildford** **GU1 4LZ** **2** [redacted] **Hampshire Highways** **The Director ETE Department** **Hampshire County Council** **Castle Avenue** **Winchester** **SO23 8UJ**
1	**CORONER** I am Christopher WILKINSON, Senior Coroner for the coroner area of Hampshire, Portsmouth and Southampton
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 17 February 2022 I commenced an investigation into the death of Seth Curtis Palminder THIND aged 25. The investigation concluded at the end of the inquest on 27 September 2022. The conclusion of the inquest was that Mr Thind had taken his own life impulsively whilst suffering an acute episode of anxiety whilst under the effects of Sertraline intoxication.
4	**CIRCUMSTANCES OF THE DEATH** At approximately 20.10 on the evening of Sunday 6 February 2022 the Deceased fell from a road bridge [redacted] as a result of which he was instantly struck by a number of southbound vehicles who had no time to avoid the collision, resulting in his instant death due to multiple injuries. The Deceased had, on Friday 4 February 2022, been discharged from Antelope House in Southampton where he had been receiving care under an informal admission since 27 December 2021 for what was believed to be emotionally unstable personality disorder and following an incident of arson at the family home. His discharge had been delayed due to difficulties in finding suitable alternative accommodation for him as he had been unable to return to his family home. This resulted in temporary lodgings having to be found for him, at short notice, as he was presenting as homeless pending a further move to new accommodation on the following Monday 7 February 2022.

	It was recognised at the time of his discharge that there were risks of further self-harming or reckless behaviour, but despite attempts by the crisis resolution home treatment team to engage with him in the 48 hours following his discharge, he was unable to be contacted. He was found to have taken an overdose of prescribed medication on the evening of 5 February 2022 for which he was hospitalised, but then discharged on the morning of 6 February. It was determined likely that he had taken a further overdose of medication during the day of 6 February 2022, which resulted in his presenting at the road bridge at [redacted] close to his temporary accommodation, [redacted] The evidence established that on the balance of probabilities he had impulsively jumped from the bridge with the intent to take his own life whilst under the influence of an overdose of prescription medication.
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) 1. At the incident location [redacted] there is little if anything by way of safety measures that would prevent anyone from being able to climb over, around or on top of the side railings of the bridge or to prevent them from jumping from the bridge to the carriageway. There is for example no enclosure of the walkway to prevent this. 2. At the incident location there are no means of summonsing help or calling for help should a person be in crisis and require assistance. There are no signs or signposting for mental health assistance or support (such as from Samaritans). 3. There are no known monitored CCTV cameras covering the bridge or approach area, rendering monitoring of a recognised danger spot actionless. 4. At the incident location, according to Hampshire Police Record Management Systems, there have been 12 crisis incidents in the last 5 years (of which the Police are aware) - including 7 self-harm (jumping) attempts, 2 successful jumps from which the individual has survived and 3 fatalities. There have been a further 89 reported 'concern for safety' incidents at the location. 5. Wider reports of self-harm incidents and fatalities are well known from [redacted] most of which do not have sufficent safety measures in place (as above) or means of summonsing help at a point of mental health crisis. 6. Deaths continue to occur as a result of individuals jumping from these bridges and insufficient measures have so far been taken to address and prevent their occurrance.
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 09, 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 **Southern Health Foundation Trust** **Trust Headquarters** **Tatchbury Mount** **Calmore** **SO40 2RZ** I have also sent it to [redacted]**- Mother** [redacted]**- Father** [redacted]**– Hampshire Police** [redacted]**– Forensic Collision Investigator** 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: 17/10/2022**  **Christopher WILKINSON** **Senior Coroner for** **Hampshire, Portsmouth and Southampton**