REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Human Resources, [redacted]
1	**CORONER** Miss Lorraine Harris, Area Coroner, East Riding of Yorkshire and City of Kingston Upon Hull.
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 9th December 2022 I commenced an investigation into the death of Elizabeth Anne WATSON, aged 33 years. The investigation concluded at the end of the inquest on 9th November 2023. The conclusion of the inquest was: *Suicide* Box 3 of the record of inquest read: *On 5th December 2022, Elizabeth Anne WATSON "Lizzie", jumped [redacted] She was declared deceased [redacted]. Lizzie was 33 years of age.* Her medical cause of death was recorded as: *1a Extensive External And Internal Injuries* *1b Fall From Height*

4	**CIRCUMSTANCES OF THE DEATH** Elizabeth Anne Watson "Lizzie" was intelligent and fun-loving. She trained as a primary school teacher. Lizzie began to suffer from anxiety and sleeping problems. Her mental health declined in 2019 causing her to become withdrawn from friends and work. In September 2022 it was agreed with her husband that their relationship was over and but they remained living in the same house by arrangement. On 3rd December 2022 there was a substantive argument. It was agreed that her husband would leave the house. The following day the couple talked. While the breakdown of the relationship was distressing it was believed that the situation had settled and decisions had been made. Lizzie appeared calm, she informed family members she would not be going to work the next day as she wanted to rest. On Monday 5th December 2022 Lizzie attended the Humber Bridge. Security staff in the control room monitored her for a matter of minutes but before assistance was requested from colleagues to approach Lizzie she jumped from the bridge, landing on Cliff Road. Lizzie was declared dead at the scene.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence 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) During evidence the matter of monitoring people who attend the bridge in mental health distress was raised. There is a minimum of 2 staff in the control room and 3 staff covering "traffic duties" on the ground. The security staff at the bridge deal with a variety of security issues however this report only seeks to address their role in relation to those suffering from mental health distress. The staff are expected to identify and monitor any person of concern entering the walkways of the bridge. This involves looking at their actions, mannerisms, behaviour and body language. Staff are expected to identify those who may require assistance and contact staffing colleagues to approach them. It appeared there was no structured training policy in place to ensure that staff are given appropriate training to deal with identifying vulnerable people. On joining, staff have an 8 weeks mentoring course, whereby an experienced colleague shows them the role and advises on what to look for. Staff may also undertake an on line suicide prevention course and mental health first aid at work as well as safety harness/working at height training. However there appeared to be no structure to any of the training for this vital role and of more concern there was no input from a trained medical professional with significant

	knowledge of working with those suffering from mental health crisis. Nor was there any current input with regard to how to talk and negotiate with people in crisis. I was informed that there were many very competent staff who had good intuition, but I have concerns that without appropriate and structured input from a health care professional, any experience on the job is based on unstable foundations. It was evident that the role is vitally important in identifying those at risk and seeking the appropriate help. Without receiving knowledge from someone trained in mental health, having a substantive input on negotiation and how to interact with those in crisis then the difficult job of assessing people and reacting appropriately with them becomes very difficult. (2) While the "Right Care/Right Person" process appears to ensure that the correct emergency service should respond if called, delays in response means often staff are left dealing with a vulnerable person for many hours due to unavailability of emergency services or mental health support. (3) I am aware that there is a [redacted] Suicide Prevention Meeting where a multi-agency approach can be taken to address the reduction of suicide [redacted]. I consider that this may be the correct forum to recognise the unique role the staff play and implement a structured training plan with all agencies input for any person beginning work in that role. (4) I was informed in evidence that a vulnerable person is escorted off the bridge everyday – this shows the extent of the problem and the staff to be provided with the very best training available. I echo the views of Lizzie's family when talking about the role that the Security Staff have "there is so much responsibility on someone's head, for them to decide whether someone is likely to jump or not". I feel that these people should be given a specific set training plan to help them do what is a vital and important role.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your department/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 Friday 5th January 2024. 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 • The family of Elizabeth Anne WATSON • Yorkshire Ambulance Service – Right Care Right Person Lead • Humberside Police – Right Care Right Person Lead • The Humber Mental Health Trust • The ICB for Humber 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 other 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.
9	**[DATE]** **[SIGNED BY CORONER]** ***10th November 2023*** ***Lorraine Harris***