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:** **1. [redacted] Chief Executive Officer, Essex Partnership NHS Foundation Trust, The Lodge, Lodge Approach, Runwell, Wickford, Essex SS117XX** **2. BRITISH TRANSPORT POLICE, 13 Selbie House, Allsop Place, London NW1 5LJ** **3.**
1	**CORONER** I am STEPHEN SIMBLET KC assistant coroner, for the coroner area of 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 and INQUEST** On 12th February 2022, the coroner commenced an investigation into the death of Amanda Susan Hitch, aged 59. The investigation concluded at the end of the inquest before me held between 13/12/2023- 15/12/2023. The conclusion of the inquest was a narrative conclusion. The deceased died of multiple injuries sustained deliberately jumping in front of a train with the intention to die. The care and treatment of the deceased's mental health needs and risk of suicide were investigated at the inquest.
4	**CIRCUMSTANCES OF THE DEATH** Amanda Hitch jumped onto railway tracks in front of a train, as I found, deliberately and intending to die, [redacted] on 12th February 2022. The risk that she would try to end her life at a station by this means was well known and chronic. She was receiving treatment in the community from a community mental health team under the Essex Partnership University Trust. This included out of hours support by ringing 111 and if thought appropriate, referral to a service called The Sanctuary, which was commissioned by EPUT but operated by people from Mind the mental health charity. The inquest considered the effectiveness of this treatment, and made findings about that in the narrative conclusion.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) During the inquest, it became clear that one significant entry in the clinical notes made by someone in a separate service commissioned by the Essex

	Partnership University Trust, and which expressed a very specific and imminent intention from the deceased to end her life, was not seen by others in the clinical team. This was almost certainly because the clinical record does not present on computer screens as a continuous chronological running record, but is instead viewed thematically. That means that readers are likely to look at entries made within their particular clinical team, rather than see what others have recorded more recently. There is an obvious risk that critical and important information garnered by others and put into the medical records will not be seen, and that those making clinical decisions on risk management will thus be unaware of potentially very significant information. (2) The evidence was such that neither the care co- Ordinator nor the consultant psychiatrist as the medical lead of the service specifically considered the structured risk management tools that the Trust operates, preferring to rely on clinical experience and judgment alone. There may be a risk that not using such risk management tools in combination with clinical experience and judgment, particularly if this is being done by one clinician at an appointment rather than multidisciplinary discussion of changes in presentation, may lead to information being missed. (3) There was also evidence about the measures that the British Transport Police had taken, seeking to provide additional support by setting up multi- agency support plan, which provided a system for alerting a number of people including the deceased's care- co-ordinator, when she attended at railway stations. In fact, for various reasons, although there are several known attendances at railway stations, none were passed on to the care co- Ordinator. The evidence at the inquest was that British Transport Police does not have the resources always to provide information about attendances at unstaffed stations (although in fact, one such attendance had been known about but was not passed on). The plan as presented does not make it entirely clear what the limitations in relation to information from attendances at unstaffed stations may be, and should it remain the position that BTP lacks the resources to identify all such attendances at railway stations by persons at specific risk of suicide on the railway, there is a risk that those expecting to receive information under such a plan may not realise that the plan will often not assist where its subject is attending unmanned stations.
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 14th February 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 and to the following Interested Persons: (1) [redacted], son of deceased, and on behalf of her family; (2) EPUT (3) British Transport Police 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	**19th December 2023** **[SIGNED BY CORONER]**