West London Coroner Service
25 Bagleys Lane, Fulham, London, SW6 2QA

Date: 21 December 2023

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

The Executive Director of Oxleas NHS Foundation Trust

CORONER

I am Hannah Hinton, Assistant Coroner for West London

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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 23 February 2023 I commenced an investigation into the death of Denise Jane PORTER. The investigation concluded at the end of the inquest. The conclusion of the inquest was: Suicide. The medical cause of death was: 1a Decapitation.

CIRCUMSTANCES OF THE DEATH

On 19th February 2023, the deceased jumped on to the tracks of Platform 2 at Turnham Green Underground Station into the path of an oncoming train. She sustained multiple injuries incompatible with life. At the time she was under the care of Oxleas NHS Trust Adults' Community Mental Health Team. She believed she had early onset dementia which was being investigated. She had poor sleep and low mood in the months prior to her death but there was no formal diagnosis for her mental condition at the time of her death.

CORONER'S CONCERNS

British Transport Police made a referral to the Older Adult Community Mental Health Team, Oxleas NHS Trust, on 25th January 2023, following an incident at Hither Green Station, when Mrs Porter had attempted to end her life by standing in front of an incoming train, which stopped.

The 9 page referral included information that Mrs Porter: "...made a deliberate act to jump onto the tracks in front of a train" and "Q: In your opinion, due to proximity of lethal means if it hadn't been for certain actions would death or serious harm have occurred? A:Yes". The summary of the incident on page 4, was only partially complete, in that it did not include the information that the train had stopped. It stated she: "decided to jump down on to the tracks to take her own life but then changed her mind and came back onto the platform".

The inquest heard the Trust did not interrogate the Safeguarding and Vulnerability Report, prepared by British Transport Police. The Trust Staff relied on the summary of the incident, both at the triage stage and subsequently during the psychiatric reviews. The Trust staff did not contact British Transport Police again to establish any information about the incident (for example the CCTV was not viewed nor a summary of the footage requested, nor were any meetings convened or discussions held between the Trust and British Transport Police).

The Trust conducted a review of the care and treatment provided to Mrs Porter. Their Report stated: "Had the referral from BTP to OACMHT included a full account of the circumstances of the incident on 25 January 2023, the OACMHT would have had a fuller understanding of the level of intent exhibited on that occasion, and subsequently risks would have been determined as high, and a more robust plan of care implemented to mitigate against these risks, that would have been immediately shared with her family". It was established at Inquest that had the full details of the incident on 25th January 2023 been understood - ie that Denise intended to take her life and this was only prevented by the slowing and halting of the train - that the psychiatrist would have referred her either to the Intensive Home Treatment Team (with consent) or for a Mental Health Act assessment (if no consent had been forthcoming).

The Trust's Report stated: "There were no identified service delivery issues that impacted on the services' ability to offer care and treatment". However, in oral evidence, the Trust's witness agreed this was inaccurate, following reflection upon the missed opportunities of investigating the events of 25th January 2023.

The Trust was unable to provide the Inquest with information to satisfy my concern that the Trust has robust systems in place to avoid the risk that staff may rely upon short summaries from British Transport Police, rather than scrutinising all the information contained within a referral and making relevant inquiries if the reporting is ambiguous or incomplete.

In this case, the Trust was clearly of the view that the detail was significant but was overly reliant upon partial information which resulted in missed opportunities for appropriate referral.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe Oxleas NHS Trust has the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report,

namely by 15th 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Next of Kin and The British Transport Police. I have also sent it to the Department of Health and Social Care who may find it useful or of interest.

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.

21 December 2023

Signature

Hannah Hinton Assistant Coroner for West London